

**AUTHORIZATION FOR RELEASE OF PATIENT RECORDS  
BRATTLEBORO NATUROPATHIC CLINIC**

**Patient/Client name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the release of my medical health records from/to Brattleboro Naturopathic Clinic including:

- € all records for my evaluation, care and treatment including drug information; emergency room records; nursing notes; laboratory results (individually copied); pathology reports; and x-ray reports.
- € laboratory test results                      pathology reports                      x-ray reports
- € HIV test results \_\_\_\_ (please initial)    □ Drug addiction/recovery information \_\_\_\_ (please initial)
- € Mental Health records \_\_\_\_ (please initial)

For the dates of \_\_\_\_\_ to \_\_\_\_\_.

I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the sole purpose of treatment is to provide information to a third party. I understand that refusing to provide information to a physician may result in redundancies or deficiencies in my care. I may inspect or copy any information used/disclosed under this authorization and understand there may be a fee for copying my health information.
- This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of The Brattleboro Naturopathic Clinic.
- If the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations and do not hold Brattleboro Naturopathic Clinic legally liable for such redisclosure.
- I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

Please release this information to:

Records released from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information will be used/disclosed for the following purposes:

- € continuing medical care
- € other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient (or his/her authorized representative, or parent or guardian)

Date

Please specify relationship to patient/client if a minor.: \_\_\_\_\_

The authorization expires \_\_\_\_\_.