AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION

Patient Name_____ DOB _____

I, _____, hereby authorize the release of medical information to the Northeast Functional Medicine. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records.

I authorize the Northeast Functional Medicine to retrieve medical records from:

Name:_____

Address:_____

_____

Phone: _____Fax: _____

I authorize the release of the following health information: (check the applicable box below)

_____All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

_____Only the following records or types of health information:

_____

_____

_____ _____

Signature Date