Natural Bridge Acupuncture
Authorization for the Release of Medical Records

This *authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.*

Patient: _____ Social Security #: _____-_____-_____ DOB:_____/_____/_____

Please **obtain** information **from** the following:

_____
Name of Physician

_____
Name of Clinic/Hospital

_____
Street Address

_____
City, State, Zip Code

Please **send** my medical information **to**:

_____@
Name of Person to Receive Information

Wendy Middleton-Bentley, L.Ac.
415 Natural Bridge Rd.
Slade, KY 40376

By ***checking*** the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information ***going back one year***. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

____ Medical records needed for continuity of care
____ Diagnostic imaging reports
____ Laboratory reports
____ Pathology reports

____ Other: _____

_____ _____
Date Patient Signature

_____
Signature of Parent/Guardian if Applicable

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By **signing** the spaces below, I specifically authorize the release of the following confidential information for use by Natural Bridge Acupuncture. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____
Patient Signature

HIV/AIDS test results and related information, including high risk behavior documentation. **This information may not be further disclosed without The specific written authorization of the tested individual**

_____
Patient Signature

Drug/Alcohol diagnosis, treatment, or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind Of information is to be disclosed. Please provide a description of this information:

_____

_____

_____
Patient Signature

Mental Health treatment information

Office use only: Date sent: _____ Initials: _____