# Medical Release Form

**Today's Date**: ___/___/___

**Patient Name**:_____ **Date of Birth:**___/___/___

## Requested From

**Provider Name**: _____
**Provider Email:** _____
**Provider Phone:** _____ **Provider Fax:** _____

## Send Information To

**Name of Recipient:** _____
**Recipient Email:**_____
**Recipient Phone:** _____ **Recipient Fax:**_____
**Recipient Street Address:**_____
**City:** _____ **State:** _____ **Zip Code:**_____

## Information to be Disclosed

*I authorize the release of the following health information:*

**Visit Notes:** ▢ **All** ▢ **Specify Dates:**_____
**Laboratory Tests:** ▢ **All** ▢ **Specify Tests:**_____
**Recommendations:** ▢ **All** ▢ **Specify Dates:**_____

▢ **All of my health information that the provider has in their possession including information related to my medical history, mental or physical conditions, and any treatment recommendations received by me.**

▢ **Please exclude the following:**_____
_____

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## Purpose

*I authorize the release of my health information (please choose one)*:

▢ **At the request of the patient** ▢ **At the request of a provider**

▢ **Other (Please Specify):**_____

## Terms

*I understand this request will remain in effect (Please choose one):*

▢ **From the date of this authorization until this specific date:** _____

▢ **Until the provider fulfills this request**

▢ **Until a specific event occurs. (Please specify):** _____

_____

## Redisclosure

I understand that My ND Integrative Health cannot guarantee the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

## Authorization

I, _____, authorize_____ to release confidential health information about me. You may release the health information specified above to _____.

## Signatures

**Patient Name:**_____

**Patient Signature:**_____

**Provider Name:**_____

**Provider Signature:**_____