Natural Family Medicine

16701 SE McGillivray Blvd., Suite 265, Vancouver, WA 98683
Phone: 360.882.1339; Fax: 360.253.8006

Authorization for Release of Medical Information

Patient Name: ____

Phone: ________________________________ Birthdate: _________________________

Please complete as much of the following information as you know:

From: ____
Doctor or Clinic Name

____
Street Address

____
City, State, Zip

____
Phone Number

____
Fax Number

To: Dr. Lori Brown
Natural Family Medicine
16701 SE McGillivray Blvd., Suite 265, Vancouver, WA 98683
Phone: 360.882.1339
Fax: 360.253.8006

I understand that my consent is required for the release of my medical records under state and federal law. I hereby consent to the release of all information noted below:

___ Chart Notes since ____
___ Laboratory Results since ____
___ Imaging Reports since ____
___ Other: ____

Signature of Patient or Legal Guardian: _________________________ Date: __________

Relationship (if signed by a representative): _____________________________________