AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:

To:

Dear

I hereby authorize and request that you release and deliver or fax to:

Centre for Natural Healing
180 Clear Creek Dr. #101
Ashland, Oregon 97520
541-488-3133 (phone) 541-488-6949 (fax)

Specifically requested medical records such as: latest laboratory, pathology and imaging reports (no film please). You may bill me for any costs. You are further requested not to disclose any information concerning my past or present medical condition to any other person without my express written permission.

Thank you for your cooperation.

In the presence of:

______________________________ Witness

______________________________ Name

______________________________ Address

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