THE NATURAL HEALTH CLINIC
LAURA SHELTON, N.D.
EMILY SHARPE, N.D.
1707 F Street
Bellingham WA 98225
Phone 360.734.1560
Fax 360.734.3027

RELEASE OF INFORMATION CONSENT FORM

Patient Name: _____ Date: _____

Date of Birth_____

To: _____

_____

_____

To whom it may concern:

Please forward a copy of the indicated medical records to The Natural Health Clinic's Dr. Laura Shelton/Dr. Emily Sharpe from the above listed practitioner. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. Please limit record to the previous two calendar years.

Thank you in advance for your prompt attention in this matter.

_____ Radiology Reports (NOT Films)

_____ Summary of Treatment _____ Lab Test Reports

_____ Medical History/Physical _____ Other _____

Sincerely,

_____
Signature (if relative, state relationship)

_____
Print name