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## AUTHORIZATION FOR RELEASE OF RECORDS

**OBTAIN FROM:**

PHYSICIAN/CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**SEND TO:**

PHYSICIAN/CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**PLEASE CHECK SPECIFIC INFORMATION REQUESTED**

ALL RECORDS:

HEALTH RECORDS FROM SPECIFIC DATES: \_\_\_\_\_

IMAGING AND LAB RESULTS

EXCEPTIONS:

DRUG AND ALCOHOL INFORMATION

HIV INFORMATION

MENTAL HEALTH INFORMATION

OTHER: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: \_\_\_\_\_