Colville Naturopathic Clinic P.S.

Randy Sandaine, N.D. & Beck Nickel, N.D.
234 North Oak
Colville, Wa 99114
(509)684-1104 phone
(509)684-0242 Fax

Request for Release of Medical Records

Patient's Name: _____ Date of Birth _____

Patient's Soc. Sec.# _____ Previous Name _____

I hereby request that my medical records located at: _____

_____

Phone: _____ Fax: _____

Be released to:

Colville Naturopathic Clinic P.S

234 North Oak St. – Colville WA 99114

(509) 684-0242 Fax

This request applies to: (Please check all that apply)

_____ All health care information (please write dates from & to if needed)

_____ Other Information (please specify what information and dates applicable)

I understand that my records may contain information regarding the diagnosis of and/or treatment of HIV (aids virus), sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for my records requested above to be released as requested.

Patient's or Authorized Signature _____ Date _____

Witness Signature _____ Date _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS DATE IT IS SIGNED