Natural Care MD
Caring for your health naturally!

Authorization to Release Protected Health Information

_____Month_____Day ____Year _____ ☐ Male ☐ Female
PATIENT First Name Middle Last Name Date of Birth

_____Month_____Day ____Year _____ ☐ Male ☐ Female
PATIENT First Name Middle Last Name Date of Birth

_____Month_____Day ____Year _____ ☐ Male ☐ Female
PATIENT First Name Middle Last Name Date of Birth

_____
Address Phone number

I HEREBY AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL(S) PROTECTED HEALTH INFORMATION:

FROM:

Facility/Physician Name _____
Address_____
City, State, Zip_____
Phone_____
Fax _____

TO:

Natural Care MD
(a.k.a Craig Ranch Pediatrics)
6850 TPC Drive Suite 100
McKinney, TX 75070
Ph: 214-383-4400
Fax: 214-383-4403
www.NaturalCareMD.com

INFORMATION TO BE RELEASED:
(Check all that apply):

☐ All Health Records
☐ Lab Reports
☐ Visits & Encounters
☐ Growth Charts/Immunization Records
☐ Other _____

INFORMATION TO BE EXCLUDED:
(Please check the appropriate areas not to be included in your request):

☐ HIV/AIDS testing/results
☐ Drug/Alcohol/Substance use/abuse
☐ Mental health
☐ Pregnancy
☐ Other _____

REASON FOR DISCLOSURE

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing/Claims
☐ Insurance
☐ Legal Purposes
☐ Other_____

I understand that this authorization will expire in 180 days or a specific date (optional) _____ from the date of this authorization. I further understand that I may revoke this authorization in writing and that revocation will not affect any actions taken before the receipt of the written revocation. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I have read this form and agree to the uses and disclosures of the information as described.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

_____
Printed Name of Patient, Parent or Legal Guardian

_____ _____
Relationship to Patient or Legal Guardian or Authorized Representative (Attach Documentation)