# Wholesome FAMILY MEDICINE

Naturopathic Primary Care for the Whole Family

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## Medical Records Request Form

By signing this form, I authorize release of confidential health information about me, by releasing a copy of my medical records, or a summary/narrative of my protected health information, to the clinic/practitioner listed above.

*HIV/AIDS: I consent to the release of any positive/negative test result for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: Initial: _____ Date: _____*

Limitations on the information to be released subject to this form are as follows:

_____

I grant permission to release my protected health information from the following provider:

Name: _____

Address: _____

Phone: _____

Fax: _____

_____ _____

Patient Signature (or parent/guardian/legal representative) Today's Date

_____ _____

Printed Name Date of Birth

This form will be considered valid for 90 days from date of signing unless authorization is revoked by patient in writing.