Authorization for the Use or Disclosure of Protected Health Information

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purpose other than treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices before signing this Authorization.

Patient Name: ____ Date of Birth: ____________

To be completed in order for Dr. Potter to obtain your previous medical records from a specific medical facility or doctor:

I, _______________________________ hereby authorize the following physician/clinic: ____ to release medical records and information to Dr. Jennifer Potter, ND.

To be completed in order for Dr. Potter to speak to your family or personal representative about scheduling and your health condition.

I, _______________________________ hereby authorize Dr. JenniferPotter, ND to communicate my health care to the following family member(s)/personal representative (PR).

a. ____
b. ____
c. ____
d. ____

Please note that unless revoked by patient in writing, this authorization release shall remain valid indefinitely.

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Patient Name (print) Patient Name (signature) Date