Authorization for Release of Medical Records

Holistic Einstein Fax 207-221-5707 Phone: 207-470-0499

Patient Name:_____ Date of Birth:_____

Phone:_____

I hereby authorize:

Practice Name_____ Practice Fax_____

To release my medical records to:

☐ Myself (there may be a fee for this service)

☐ Holistic Einstein
219 Mill St., Rockport, ME 04856
Fax: 207-221-5707 Phone: 207-470-0499
Web: www.holistic-einstein.com Email: dan@holistic-einstein.com

For the purpose of this request my medical records include

☐ All Records (excluding billing records)

☐ The following specific records:_____

I understand that

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- I may receive a copy of this authorization upon signature if requested.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing a written request at any time.
- I may review any documents released. After review I may cross out any statements with which I disagree, or add a statement of my position. Doing this may result in delayed or improper diagnosis and treatment.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signed (Patient or legal representative/guardian):_____ Date:_____

Print Name:_____

Relationship to patient (if legal representative/guardian):_____