



Hegnauer Holistic Health
Dr. Amanda Hegnauer, ND
Naturopathic Doctor

Records Release Authorization

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

Signature: _____ Today's Date: _____

I hereby authorize:

Hegnauer Holistic Health
77 Penacook Road, Sutton, NH 03260
P: (603) 927-4880
F: (877) 254-6906

To release information to:

P: _____
F: _____

P: _____
F: _____

Hegnauer Holistic Health
77 Penacook Road, Sutton, NH 03260
P: (603) 927-4880
F: (877) 254-6906

PURPOSE OF DISCLOSURE:

- Continuing care
- Payment of claim
- Legal
- Other (specify): _____
- Worker's compensation
- School
- For personal use

INFORMATION TO BE RELEASED

Between the dates of: _____

- Progress notes/Provider notes _____
- Lab reports/Pathology _____
- X-Ray reports _____
- X-Ray films/MRI _____
- Other (specify content and dates): _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.