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
11 East Main Street, Warner, NH 03278
P: (603) 456-2453
F: (603) 635-4845

( ) _____
_____
P: _____
F: _____

To release information to:
( ) _____
_____
P: _____
F: _____

( ) Hegnauer Holistic Health
11 East Main Street, Warner, NH 03278
P: (603) 456-2453
F: (603) 635-4845

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

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.