



Payson Flattery, ND, DC, PC

## AUTHORIZATION FOR RELEASE OF RECORDS

**OBTAIN FROM:**

PHYSICIAN/CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**SEND TO:**

PHYSICIAN/CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**PLEASE CHECK SPECIFIC INFORMATION REQUESTED ALL**

**RECORDS:**

HEALTH RECORDS FROM SPECIFIC DATES: \_\_\_\_\_

IMAGING AND LAB RESULTS

**EXCEPTIONS:**

DRUG AND ALCOHOL INFORMATION

HIV INFORMATION

MENTAL HEALTH INFORMATION

OTHER: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: \_\_\_\_\_

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