RIVERBEND
INTEGRATIVE MEDICINE

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Authorization to Disclose Protected Health Information

please note there will be a $15 processing fee for all records e-mailed, faxed, or mailed directly to patient
Payment required before release of records.

Patient Name: _____ DOB: _____

Patient Address: _____ City, State, Zip: _____

Information to be disclosed FROM:

- ☐ Carla Brook, NP-C
- ☐ Other Doctor and/or Medical Facility: _____
  Address: _____ City, State, Zip: _____
  Phone: _____ Fax: _____

Information to be disclosed TO:

- ☐ Self: _____
- ☐ Other Clinic/Physician: _____

Address: _____

City, State, Zip: _____

Phone Number: _____Fax Number: _____

I authorize the disclosure of:

- ☐ All records from _____ to _____
- ☐ Entire records (complete)
- ☐ Progress Notes
- ☐ Lab Results
- ☐ Other: _____

Information to be:

- ☐ Faxed / Fax Number: _____
- ☐ E-mailed / E-mail Address: _____
- ☐ Mailed / Mailing Address: _____

Signature of patient or patient representative: _____

Date: _____