



**Idaho Naturopathic Medicine**  
facilitating health and healing

Dr. Sara Rodgers ND, C.Ac.  
3113 Rose Hill Road, Boise, ID 83705  
122 1/2 Oregon St. Ontario, OR 97914  
PH: 208-275-0007 FAX: 208-514-4563  
www.idnatmed.com

**PATIENT AUTHORIZATION FORM FOR RELEASE OF RECORDS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

Authorizes the release/exchange of information between the following parties:

TO / FROM

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO / FROM

Sara Rodgers, ND, C.Ac.  
Idaho Naturoatpathic Medicine  
3113 Rose Hill Road, Boise, ID 83705  
122 1/2 Oregon St. Ontario, OR 97914  
Fax 208-514-4563

Specified Information Requested:

- Complete records including notes and laboratory results
- Records pertaining to \_\_\_\_\_
- Lab/Test Results
- Other \_\_\_\_\_
- Verbal

Purpose for release of information:

\_\_\_\_\_  
\_\_\_\_\_

I understand that my records are protected under the Federal confidentiality regulations (42 CFR Part 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

If you do not wish to release records containing information regarding diagnosis or treatment of HIV (AIDS), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment, please initial here \_\_\_\_\_. Unless initialed here this information is deemed permissible to release.

I hereby consent to the release of the above requested information. This consent will expire ONE YEAR after the date it is signed, or sooner at my written request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or legal guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_