Dr. Sara Rodgers NMD/ND, C.Ac.
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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, NMD/ND, C.Ac.
Idaho Naturoatpathic Medicine
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:____________________________