Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

Medical Records Release

I request the release of information regarding _____
Patient's Name

Date of Birth:_____

FROM:
Provider/Group name::_____

Address:_____

City/State/Zip_____

TO:
Provider/Group/Other: Full Circle Center for Integrative Medicine

Address: 4641 Valley East Blvd #2

City/State/Zip: Arcata CA 95521

I specifically need the following information released (INITIAL EACH ITEM):

___ All information regarding the assessment, diagnosis, and treatment of_____
___ All information regarding the care provided from _____ until _____
Date Date

Unless "No is written in and initialed, the records will include the following:
Alcohol and drug use/abuse __ _____ Mental Health Information __ _____ HIV status __ _____
No Initials No Initials No Initials

___ Other _____

_____

Lab Results _____ TB results _____ EKG report _____

Immunizations _____ X-ray results _____ Consults _____

The person receiving this information may only use it for the following purposes:
__ Assessment & Evaluation __ Legal Proceedings of Legal Advice __ Employment
__ Health Insurance Enrollment __ School or Educational Needs __ Personal Use
__Aid or Entitlement __Other (Specify) _____

This consent shall remain valid for one year from date of signature unless otherwise specified.

_____ _____
Date Patient, Parent, Conservator, or Guardian (Circle one)

_____ _____
Date Witness Signature

The patient has the right to receive a copy of this authorization.