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AUTHORIZATION TO RELEASE INFORMATION

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize____(name of hospital/heath care

provider) to release a copy of the medical information

for_______________________________________ (name of patient) __________(date of birth) to

Krista Anderson Ross ND FOR THE PURPOSES OF EXAMINATION / REVIEW.

I authorize you to provide copies of the following initialed records. **PLEASE INITIAL.**

Entire record

___Most recent five year history

___specific information____

___Old records from previous physicians

___Diagnostic imaging reports

___Lab results:

___Pathology reports

Other:____

I give special permission to release any information regarding (initial applicable lines below):

_______ Substance abuse _________ HIV information

_______ Psychiatric/Mental health information

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

(Signature of Patient or Legal Guardian) (Date)

(Signature of person authorized by law) (Date)