



**RELEASE OF CONFIDENTIAL HEALTH RECORDS AUTHORIZATION**

I, \_\_\_\_\_, patient of Dr. Emma Baker ND, authorize the release of the following indicated health records:

*Patient to initial:*

\_\_\_\_\_ all lab records      \_\_\_\_\_ all imaging records      \_\_\_\_\_ complete medical record

\_\_\_\_\_ specific records as follows: \_\_\_\_\_

**From:**

Health Provider or Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**To:**

Health Provider or Facility Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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

Witness Signature: \_\_\_\_\_

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