Lisa Rosenberger, ND, LAc
East West Integrative Health Clinic, LLC
217 Montowese St.
Branford, CT 06405
ph 203.915.9125 fax203.643.4340

AUTHORIZATION FOR RELEASE OF RECORDS

Physician: _____
Address: _____
_____
_____

Patients name: _____
Date of Birth: _____

Please release the following records to this office:
_____Health records (history, physical exam, discharge summaries, surgical reports, etc.)
_____Laboratory test results
_____X-ray, CT, MRI, US and reports
_____Other _____
for the following period:
_____previous month _____previous six months
_____previous year _____since first office visit

Date requested: _____ Date sent: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Patient's signature: _____

Requesting physician: _____

Physician's signature: _____