Dr. Natalie Metz, ND
5299 College Ave, Ste P, #3, Oakland, CA 94618
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO DR. NATALIE METZ, ND

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.

FROM: PATIENT'S INFORMATION: Full Name _____ DOB _____
(please print neatly) (Month/Day/Year)

Patient's Address _____
(street #) (unit #)

_____
(city) (state) (zip code)

Patient's Telephone _____ _____
(home (include area code)) (office/cell (include area code))

TO: DOCTOR YOU ARE REQUESTING RECORDS *FROM*:

Dr._____ Clinic Name_____
(Doctor's full name)

Telephone _____ FAX _____

Address _____
(street #) (unit #)

_____
(city) (state) (zip code)

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information to Dr. Natalie Metz, ND. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation, fax, or electronically:

____ Laboratory reports ____ Diagnostic imaging reports ____ Medical records

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R Part 2. By signing the spaces below, I specifically authorize the release of the following confidential information. I understand that I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation, fax or electronically.

_____ HIV/AIDS test results and related information, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of the tested individual.

_____ Drug/alcohol diagnosis, treatment, or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description.

_____ Mental health treatment information.

Patient or Legal Guardian Signature

I authorize release of these records to Dr. Natalie Metz, ND, 5299 College Ave, Ste P, #3, Oakland, CA 94618
I understand there may be a fee associated with this request, and I consent to pay this fee. I release Dr. Natalie Metz, ND and Nature Cares Medicine from all legal responsibility or liability that may arise from this authorization.

Signed_____ Date _____
Patient or Legal Guardian

PLEASE FAX RECORDS TO (888) 980-9765