CONSENT TO DISCUSS MEDICAL RECORDS

Patient Name (Print): _____

Date of Birth: _____

I authorize Northwest Integrative Medicine (NWIM) to discuss my medical information with the following individuals (Print all names listed below):

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

I give my permission for NWIM to leave medical information at my home / cell telephone number. [ ] Yes [ ] No

_____ _____

(Signature of Patient, Parent, or Legal Guardian) (Date Signed)

_____

(Printed name of signature above)

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MEDICAL RECORDS INFORMATION

Dr. Smith requires all patients to have a PCP (primary care provider) or specialist they have seen within the last 12 months receive copies of your medical records.

PCP/Specialist Name: _____

Address: _____

_____

Phone: _____ FAX: _____