NORTHEAST
FUNCTIONAL MEDICINE

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name___________________________ DOB ________________

I, __________________________________, herby authorize the release of medical information from Northeast Functional Medicine. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records.

I authorize Northeast Functional Medicine to send medical records to:

Name:____

Address:____

____

Phone: ___________________________Fax: ______________________

I authorize the release of the following health information: (check the applicable box below)

______All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

______Only the following records or types of health information:

CONTACT 781.222.8100 WITH ANY QUESTIONS.

___________________ ____________________

Signature Date