

Rockwood Natural Medicine Clinic
Authorization for Release of Records

REQUESTING RECORDS FROM:

Physician's Office Name: _____

Address: _____

City: _____ State: _____

Zip _____ Tel# _____ Fax # _____

Name of Patient (Please Print): _____

PLEASE RELEASE THE FOLLOWING RECORDS:

Health Records _____ X-Rays _____ Lab Results _____

Other: _____

Requested By:

_____ Thomas Kruzel, ND

_____ Decker Weiss, NMD, FASA

_____ Sara Hazel, ND

_____ Other: _____

Patient Signature: _____

DOB: _____

Date Requested: _____ Date Sent: _____

