Provider: Nathan Walsh, ND
Fax #: 888.972.9655

Release of Medical Records Request

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. World Tree Wellness does not offer reimbursement for records received.

Patient Name (Please Print): ______________________________ Date of Birth: _____ / _____ / _____

______________________________ ______________________________
Address Phone

Provider/Clinic: ______________________________

______________________________ ______________________________
Address Phone

______________________________ ______________________________
Email Fax

Please Release the Following Information

By checking the spaced below, I authorize the above provider/clinic/hospital to release written records pertaining to the following information. I also authorize the above provider/clinic/hospital to provide the following information via telephone consultation:

- ☐ Chart Notes, specifically: ______________________________
- ☐ Labs & Diagnostic, specifically: ______________________________
- ☐ Imaging Only, specifically: ______________________________
- ☐ Other: ______________________________

Patient Signature: ______________________________ Date: _____ / _____ / _____

Parent/Guardian Signature (if applicable): ______________________________ Date: _____ / _____ / _____

Confidential Information

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By initialing the spaced below, I specifically authorize the release of the following confidential information to World Tree Wellness. I also authorize the above provider/clinic/hospital to provide the following information via telephone consultation.

________ HIV/AIDS test results and related information, including high risk behavior documentation.

________ Drug/Alcohol diagnosis, treatment, or referral information.

________ Mental Health information.

Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:

____

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Please Fax to 888.972.9655 as soon as possible

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