LAUREN VREELAND, N.D.

Naturopathic Medicine

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Authorization to Release Confidential Health Information

I hereby authorize:

Facility Name: ____
Address: ____
City/State/Zip: ____

To release information from the health records of:

Name ____
Date of Birth ____/ ____/ ____ ID/ Soc. Sec. # ______________________
Dates of service: From _______ To ________ Day Phone ___________

Information to be Released:

____ Copy of complete health records
____ Lab/Test Results
____ X-Ray Reports and/or films (specify) ________________________
____ Other (specify) ____
____ Billing information for dates of service ________________________

Information is to be released to:

Facility Name: Lauren Vreeland, ND
Address: 1831 Orange Ave, Suite A
Costa Mesa, CA 92627

Purpose of disclosure ____

This authorization is valid for ninety (90) days from the date signed. I understand that I can revoke this consent at any time, unless disclosure has already occurred in compliance with this consent.

Unless specifically excluded, this authorization includes release of ***specially protected information*** requiring specific written consent. This includes referral diagnosis and treatment related to substance abuse, mental health conditions and sexually transmitted diseases including HIV (CFR 42, part 2). Release of certain information also requires a ***minor's consent***. This Applies to persons aged 13 to 18 for information pertaining to sexually transmitted diseases and HIV/AIDS.

I also understand that my information and records are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent, unless otherwise provided for by law.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in patient care, there may be a charge. There is no charge for records mailed directly to another health provider.

Patient/Guardian Signature ___________________________ Date ________________

Witness Signature _____________________ Relationship to patient _____________