Medical Records Release Form

Please note: Records that consist of more than 5 pages should be mailed rather than faxed.

Last name First name MI

Date of Birth_____

I hereby authorize Dr. Toni Varela, ND to release and/or receive information to/from:

( ) Your Business Name

Your Address

City, state zip

P: your phone

( ) Your Business Name

Your Address

City, state zip

P: your phone

PURPOSE OF DISCLOSURE:

( ) Continuing care
( ) Worker's compensation
( ) Payment of claim
( ) School
( ) Legal
( ) For personal use
( ) Other (specify): _____

INFORMATION TO BE RELEASED

Between the dates of: _____

( ) Progress notes/Provider notes_____

( ) Lab reports/Pathology_____
( ) X-Ray reports_____
( ) X-Ray films/MRI_____
( ) Other (specify content and dates):_____

Dr. Toni Varela, ND
Please visit or call for clinic
information www.drtonivarela.com
925-786-0375