Authorization for the Release of Medical Records

This authorization must be written, dated and signed by the patient or guardian. It is valid until revoked in writing. Records are requested for continuity of care.

Patient: _____ Social Security #: _____-_____-_____
DOB:_____/_____/_____

Please **obtain** information **from** the following:

_____
Name of Physician

_____
Name of Clinic/Hospital

_____
Street Address

_____
City, State, Zip Code

Please **send** my medical information **to**:

_____@
Name of Person to Receive Information

Katherine Altneu, L.Ac.
1705 South Pearl Street #4
Denver, CO 80210

By ***checking*** the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information ***going back one year***. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

____ Medical records needed for continuity of care
____ Diagnostic imaging reports
____ Laboratory reports
____ Pathology reports

____ Other: _____

_____ Date

_____ Patient or Guardian Signature

Office use only: Date sent: _____ Initials: _____