Anita M. Larrow, ND
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Authorization for Release of Protected Health Information Records

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Patient Legal Name | Date of Birth

( )
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Address | Phone Number

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City | State | Zip Code

I hereby authorize (your current Doctor's full name, address and phone number)

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To disclose protected health information to:

Dr. Anita M. Larrow, ND at 2732 Chamise Ct., Fairfield, CA. 94533

- Reason to release protected health information: ___________________________________
- Time frame of records: ________________________________
- Type of access requested (copies of the records):
  - ➢ Chart notes
  - ➢ Tincture formulations
  - ➢ Laboratory reports / results
  - ➢ Medication records
  - ➢ Correspondences (i.e. phone messages and emails)
  - ➢ Other ____________________________

- I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that the term, entire record, regarding release of protected Health Information means that only records generated by the named facility will be released.
- I have read the above and authorize the disclosure of the protected health information.

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Signature of Patient / Parent / Legal Guardian | Date