**Beth DiDomenico, ND**

**Medical Record Release Authorization**

**Patient Information**

- Patient's Full Name: _____Date of Birth: _____
- Address:_____
- City: _____State: _____Zip: _____
- Phone Number: _____
- **Authorization:** I authorize _____to release my medical records to the following individual/entity:
- Name of Recipient: **Beth DiDomenico, ND**
- Address: **117 Stafford Street**
- City: **Leavenworth** State: **WA** Zip: **98826**
- Phone Number: **253-544-3466** Fax: **833-438-6650**

**Purpose of Release:** This authorization is for the purpose of:

◯ Continuity of Care

**Records to Be Released:** Please specify the medical records to be released. You may choose to release all records or specify particular documents, dates, or categories of information:

◯ All Medical Records

◯ Specific Documents/Dates/Categories (please specify): _____

**Method of Release:**

◯ Electronic Transmission (Please provide secure portal information): _____

◯ Fax (Please provide fax number): _____

◯ Paper Copy_____

**Patient's Signature:** I understand that I have the right to revoke this authorization at any time by providing written notice to _____. I also understand that once my medical records are disclosed, they may no longer be protected by federal or state privacy laws.

**Patient's Full Name: _____**

**Signature: _____Date: _____**