SATORI
HEALING

Medical Record Release Authorization

Patient Name: _____DOB: _____
Phone: _____

Alternate Names (Maiden name , etc.)

_____

Release From: _____

_____

_____

Send To: _____

_____

_____

Release copies of the following: (check)

All medical records (last 3 years)

For the purpose of:

_____Continuing Care Personal Copy

_____Disability Determination

_____Immunization Records

_____Insurance Claim Legal Claim Other:

_____Test Results

This authorization is in effect for the following time period. Upon conclusion of this time period, this authorization is automatically revoked.

Time Period: _____

To_____ Patient / Legal

Guardian Signature _____Date:_____

2610 Trinity Dr. #14 • Los Alamos, NM 87544 • Phone: 505-500-8213 • Fax: 505-451-0580