Natural Health Center, P.C.
Shawn M. Schmidt, BS, DC, FIACA, CCN
8001 Chicago Street
Omaha, NE 68114
402-399-2020
402-399-0707-fax

Authorization for the Release of Medical Records

Patient Name:_____Date of Birth:_____
(also list maiden name/other names used)
Social Security Number:_____

I hereby request and authorize:

Natural Health Center, P.C.
Shawn Schmidt, BS, DC, FIACA, CCN, DCCN, CBCN
8001 Chicago Street
Omaha, NE 68114
402-399-2020-phone
402-399-0707-fax

_____**To Disclose information to:** _____**To Receive Information from:**

Provider:_____
Address:_____
City/State/Zip_____
Phone number:_____ Fax Number:_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)_____

This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____Date:_____
Signature of Patient/Legal Representative/Relationship
(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

_____Date:_____
Signature of Witness

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.
Rev 04/2011