CONFIDENTIAL MEDICAL INFORMATION RELEASE/REQUEST

I hereby authorize:

Facility Name/Doctor: _____

Mailing Address: _____

Phone/Fax: _____

To release from the health records of:

Patient Name: _____

Date of Birth: _____

SSN: _____

Daytime Phone: _____

The following information:

[ ] Copy of Complete Health Record

[ ] Lab Results

[ ] Other: _____

Dates of treatment:

From: _____ To: _____

Information to be released to:

[ ] Dr. Brandi Solace – NPI# 1295882850

Solace Natural Medicine, PLLC
P.O. Box 129 · 301 Colorado Street
McCall, ID 83638
(208) 634-7289 Fax (208) 634-1082

I understand that some of the information released may include diagnosis and/or treatment of HIV, other sexually transmitted diseases, drug and/or alcohol abuse, mental health status or psychiatric treatment. Further release of this information to other parties cannot be done without my authorization. I hereby release the practitioner/s and associated staff from legal responsibility that may arise from the act hereby authorized.

Patient Signature: _____ Date: _____