NATUROPATHIC FAMILY MEDICINE
Jennifer Zeglen, ND

Authorization to Release Confidential Health Information

I Hereby Authorize:

Jennifer Zeglen, ND
Facility/Doctor's Name: ___
Address: ___
City: ___ State: ___ Zip: ___-___
Phone #: ___ Fax #: ___

To Release:

Complete Chart Record *(does not include billing information or radiographic images)*
Chart Notes: All Specify: ___
Labs/Reports: All Specify: ___
Other: ___

From the Health Records of:

Name: ___ Date of Birth: ___/___/___
Soc. Sec. Number: ___ Day Phone: ___ ext:: ___

Are you authorizing release of your own records? Yes No
If not, what is your relationship to the Patient? ___

Release of certain medical information requires a minor's consent. This applies to minors age 12-17 for information pertaining to substance abuse, certain mental health information, infectious diseases, sexually transmitted diseases, HIV/AIDS, and rape. Other laws may apply.

To be Released to:

Jennifer Zeglen, ND Self (please provide current address below) ***fee may apply**
Facility/Doctor's Name: ___
Address: ___
City: ___ State: ___ Zip: ___-___
Phone #: ___ Fax #: ___

For the Purpose of:

Adjunctive/Concurrent Care Transfer of Care Other: ___

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document..

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:
(check the accompanying box(s) below to EXCLUDE the information from authorization)
substance abuse mental health conditions/psychotherapy sexually transmitted diseases and HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing.

Patient's Signature: ___ **Date** ___

Rep./Guardian's Signature: ___ **Date:** ___

1991 Village Park Way, Suite 206A ■ Encinitas, CA 92024 ■ Ph)760-216-8769 ■ Fax) 866-339-3412