Release of Information

Name: _____ _____ _____ _____
Last First Middle Initial DOB

Address: _____ _____ _____ _____
Street City State Zip Code

Phone Number: _____ _____
Daytime Phone Alternate Phone

Email Address: _____

Release Information From:	
Natural Solutions by KC	o

Release Information To:	
Self	o
Other	o
Name:	_____
Address:	_____
Phone:	_____
Fax:	_____
Email:	_____

Dates of Service Requested: _____ _____
From To

Information to be disclosed:		
	Medical History	o
	Office Notes	o
	Payment Invoices	o
	Consent Forms	o
	Other	o

Release Method: o Mail o Fax o Email o Pickup

Purpose of Release of Information:
o Further Medical Care o Insurance/Eligibility o Changing Physicians o Self o Other

Client Signature: _____ Date: _____