***Holistic*ND**
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Consent for Release of Medical Information

Full Legal Name Date of Birth

Address

Request:

_____ Records from outside facility sent **TO** HolisticND

_____ Records sent **FROM** HolisticND to outside facility

Name of Facility/Provider

Address, Phone Number, Fax Number (if known)

Records Requested:

I agree to the above release of my medical records. This consent is valid for 1 year from the date indicated, unless I terminate prior to that date.

Signature **Today's Date**

Parent/Guardian Printed Name *Parent/Guardian Signature*
(If under the age of 18 or under Guardianship)