Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

Medical Records Release and Permission to Discuss

Patient Name: _____

Date of Birth: _____

I give permission to Full Circle Center to verbally discuss or to release written medical records regarding the following medical information about me (check all boxes that apply):

❒ Medical information, including my symptoms, diagnosis, medications and treatment plan

❒ Behavioral Health information, including my symptoms, diagnosis, medications and treatment plan

❒ Lab/test results

WITH/TO:

1. Provider/Group/Other: _____

Address: _____

Phone: _____

2. Provider/Group/Other: _____

Address: _____

Phone: _____

3. Provider/Group/Other: _____

Address: _____

Phone: _____

The persons receiving this information may only use it for the following purposes:

___ Assessment & Evaluation

___ Coordination of care plan

This consent shall remain valid for one year from date of signature unless otherwise specified.

_____ _____

Date Patient, Parent, Conservator, or Guardian (Circle one)

_____ _____

Date Witness Signature

The patient has the right to receive a copy of this authorization.