



Records Release Authorization

To: _____
(Doctor/Hospital)

Address: _____

Phone: _____ Fax: _____

I hereby authorize and request you to release to:
Lewis Family Natural Health
16 Sterling Street
Asheville, NC 28803
Phone: 828-298-4800 Fax: 866-400-9118

The following information:

- _____ Lab only
- _____ X-ray only
- _____ Complete Medical Records

I authorize the release of photocopies of the following medical records and/or x-ray files. Records or files shall include all confidential communicable disease-related information, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Concerning my illness and/or treatment from _____ to _____.

Name: _____

Address: _____

SS# or DOB: _____

Signature: _____ Date: _____

Witness: _____ Date: _____