Dr. Amy Hawkins, ND
NATUROPATHIC FAMILY WELLNESS
natural health for the whole family

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Street Address: _____ SSN: _____

City, State, Zip Code: _____ Phone: _____

At the request of the individual, I_____, do hereby authorize

Name of doctor/clinic: _____

Address of doctor/clinic: _____

Phone: _____ Fax: _____

TO RELEASE/RECEIVE THE FOLLOWING:

_____Progress Notes _____Laboratory/Radiology Reports

_____Hospital Reports _____EKG Reports

_____Complete Medical Record _____Specialist Correspondence

_____Other:

_____I do_____I do NOT authorize release of information related to AIDS or HIV infection, psychiatric care and/or psychological assessment or treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO/RECEIVE INFORMATION FROM:

DR. AMY HAWKINS
mailing address: PO Box 1414 Wrightsville Beach, NC 28480
phone: 910-367-5150
fax: 910-795-1365
email: drhawkinsnd@gmail.com

PURPOSE OF DISCLOSURE:

_____Adjunctive Care _____Transfer of Care

This authorization shall be in effect until_____at which time this authorization expires. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

Signature of patient or legal guardian:_____Date: _____