Name:_____ DOB:_____ Date:_____

AUTHORIZATION TO COMMUNICATE INFORMATION REGARDING MY CARE *Please initial or sign where indicated*

_____ I authorize the release of information regarding my on-going care to the following Physicians:
Initials

Doctors Name: _____

Address:_____

Phone:_____

Fax:_____

Email:_____

Doctors Name: _____

Address:_____

Phone:_____

Fax:_____

Email:_____

_____ I authorize the release of information regarding my on-going care on the voicemail, fax or answering machine attached to any number provided by me to ***A Natural Path***
Initials

_____ I authorize the release of information regarding my on-going care to me by any email address provided by me to ***A Natural Path***
Initials

_____ I authorize the release of information regarding my on-going care to the following people
Initials

Name: _____

Name: _____

Name: _____

_____ Date_____
Signature of Patient (or his/her authorized representative, or parent or guardian)

Please specify relationship to patient/client if a minor: _____

This Authorization may be revoked in whole or part at anytime by writing to A Natural Path.