CENTRE DOWNE HEALTH LLC

Naturopathic Family Medicine and Acupuncture

Dr. Brian Paterson, ND, Lac **Dr. Kathryn Cranford, ND, NHCM**

203 Pickerel Pond Rd. Laconia, NH 03246 phone: 603-524-9261 fax: 603-279-8870

RELEASE OF RECORDS

Name of Patient _____ Date of Birth _____

Address _____

City _____ State _____ ZIP _____ Phone _____

REQUESTING RECORDS FROM:

Care Provider and/or Clinic Name _____

Address _____

City _____ State ____ ZIP _____ Phone _____ Fax _____

PLEASE RELEASE THE FOLLOWING RECORDS:

Health Records X-ray/ Imaging Reports Lab Results

Other_____

I understand that my record may contain information related to drug and/or alcohol use, psychiatric treatment, sexually transmitted disease, including HIV or other sensitive information. I agree to its release by signing below.

PATIENT'S SIGNATURE _____Date _____

Information that I refuse to disclose _____

PATIENT'S SIGNATURE _____Date _____

This authorization expires ____ months from the date above. However, I understand that I can revoke this authorization at any time by notifying the office, in writing, signed and dated, and shall be effective when received.
I understand that I am entitled to a copy of this release form.

SEND RECORDS TO: **Centre Downe Health, LLC fax: 603-279-8870**
203 Pickerel Pond Rd.
Laconia, NH 03246

PATIENT'S SIGNATURE _____Date _____