LAKESIDE
Natural Medicine

Last Name	First Name	MI	Maiden/Other Name	Date of Birth
Address	**City**	**State**	**Zip**	**Telephone**

I authorize and request: Name and Address _____ _____ _____ _____	**To release records to:** Lakeside Natural Medicine 4433 N. Oakland Ave Shorewood, WI 53211 Ph: 414-939-8748 Fax: 414-939-8748
The following information: o History and Physical o Progress Notes o Laboratory Reports o Pathology Reports o Radiology Reports o Other _____	For the following dates: From: To:

The purpose of this authorization is continued health care. I may inspect at no charge, and may arrange for photocopies for a reasonable charge, the record or information that is to be used or disclosed by contacting Lakeside Natural Medicine, LLC. I understand that insurance coverage pertaining to this health care information dose not carry forward to care given by my provider at Lakeside Natural Medicine.

I understand that a photocopy of this authorization shall be considered as valid as the original. I may revoke this authorization at any time through written notice, effective upon receipt, except to the extent that information has already been released in reliance upon the authorization. I understand that I am under no obligation to sign this form.

Name (Printed)

Signature (Parent/Guardian if patient is a minor)	Date