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 3510 N. Oakland Ave - #203 Shorewood, WI 53211 Ph: 414-939-8748 Fax: 414-377-4203
The following information: ○ History and Physical ○ Progress Notes ○ Laboratory Reports ○ Pathology Reports ○ Radiology Reports ○ 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 does not carry forward to care given by my practitioner 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

Confidentiality notice: The content of this fax including any attachments, is for the sole use of the intended recipient and are confidential and privileged. Any unauthorized review, use or distribution is prohibited. If you are not the intended recipient, please contact the sender.