GREEN HOUSE
NATURAL MEDICINE

Patient Consent of Release Medical Information
To Individuals/Family Members

Name: _____Date of Birth: _____

[ ] I authorize the release of information including diagnosis, lab results, treatment plans and health information. This information may be released to:

_____ _____
NAME RELATIONSHIP TO PATIENT

Health information and test results of a sensitive nature will ONLY be given directly to the patient.

[ ] I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

[ ] I understand that I have the right to revoke this authorization, in writing, at any time.

[ ] I understand that this authorization will remain in effect for a period of six (6) months from its date of origin unless terminated in writing prior to that date.

_____ _____
Patient Signature Date

_____
Expires on