GREEN HOUSE
NATURAL MEDICINE

Permission to Share Patient Health Information

I, _____, Date of Birth, _____/_____/_____. Herby request that Greenhouse Natural Medicine please release and provide a copy of the following, for the purpose of providing information that may benefit my treatment. I am aware that I may rescind this permission at any time in writing.

	1 year or	**from**
☐ Complete medical records (all of below)	☐	_____ to_____
Or		
☐ Patient progress notes	☐	_____ to_____
☐ Lab tests	☐	_____ to_____
☐ Medications	☐	_____ to_____

** Requests for more than 1 year of information may incur a small chargeof $15, for time and materials*

Specific Authorization: **(initial all that apply)** I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to EITHER or ALL of these items. My signature below authorizes release of all such information**.**	_____ HIV test results _____ Mental health treatment _____ Alcohol/drug treatment

Please send my records to:

Name _____

Address _____

City, State & Zip _____

Phone _____ Fax _____

*Record requests are processed **WITHIN 7-10 BUSINESS DAYS.** 3-day Rush-Processing is available for an additional fee of $35. Please contact the office to arrange.*

Please send my records via: ☐ Fax ☐ 1st Class mail

Additional Information

I understand that:

~ Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.

Signature: _____ Date: _____

Julia Greenspan, ND … Cheryl Celia, FNP … Miriam Mendelsohn, ND

109 Ponemah Rd. Suite 9
Amherst, NH 03031

Phone 603-249-5771
Fax 603-249-5924