



**Records Request**

I, \_\_\_\_\_, Date of Birth, \_\_\_\_/\_\_\_\_/\_\_\_\_. Herby request:

Doctor's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State & Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

To release and provide a copy of the following

- |  | <u>1 year</u>            | <u>or</u> | <u>from</u>    |
|--|--------------------------|-----------|----------------|
| <input type="checkbox"/> Complete medical records (all of below) | <input type="checkbox"/> |           | _____ to _____ |
| Or   |                          |           |                |
| <input type="checkbox"/> Patient progress notes                  | <input type="checkbox"/> |           | _____ to _____ |
| <input type="checkbox"/> Consults                                | <input type="checkbox"/> |           | _____ to _____ |
| <input type="checkbox"/> Lab tests                               | <input type="checkbox"/> |           | _____ to _____ |
| <input type="checkbox"/> CAT scans, US, MRIs & X-rays            | <input type="checkbox"/> |           | _____ to _____ |
| <input type="checkbox"/> Pathology                               | <input type="checkbox"/> |           | _____ to _____ |
| <input type="checkbox"/> Medications                             | <input type="checkbox"/> |           | _____ to _____ |

For the purpose of providing information that may benefit my treatment.

Please send my records to:  
**Greenhouse Natural Medicine**  
**109 Ponemah Rd Suite 9**  
**Amherst, NH 03031**  
**603-249-5771 Fax: 603-249-5924**

Please send my records via:  Fax  1<sup>st</sup> Class mail

Signature: \_\_\_\_\_ Date: \_\_\_\_\_