GREEN HOUSE
NATURAL MEDICINE

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

		1 year or	**from**
☐	Complete medical records (all of below)	☐	_____ to_____
Or			
☐	Patient progress notes	☐	_____ to_____
☐	Consults	☐	_____ to_____
☐	Lab tests	☐	_____ to_____
☐	CAT scans, US, MRIs & X-rays	☐	_____ to_____
☐	Pathology	☐	_____ to_____
☐	Medications	☐	_____ 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 ☐ 1st Class mail

Signature: _____ Date: _____