



PACIFIC NATUROPATHIC
M E D I C A L C E N T E R

Authorization for release of information as deemed under the HIPPA (Health Insurance portability and Accountability Act of 1996) compliance with Privacy Standard Code 164.508(b)(6).

I, _____ **the undersigned do hereby authorize:**

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To release the following information to:

- Complete chart
- Progress Notes
- Labs and Imaging
- Medication History

(Hospital, Physician, Clinic)

(Address, City, State, Zip)

(Phone & Fax Numbers)

Signature of Patient

Date

Date of Birth

Social Security Number

Witness

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