

## MEDICAL RELEASE FORM

\_\_\_\_\_  
Patient's Name

I hereby authorize Dr. Renee Lang, ND to  
**obtain** information from (person or agency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Dr. Renee Lang, ND to  
**release** information to (person or agency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The specific information to be disclosed is:

- |  |   |
|--|---|
| <input type="checkbox"/> Office Visit Notes        | <input type="checkbox"/> Referral Report              |
| <input type="checkbox"/> New Patient Questionnaire | <input type="checkbox"/> Pharmacy Sheets              |
| <input type="checkbox"/> Treatment Plans           | <input type="checkbox"/> Phone contact as needed      |
| <input type="checkbox"/> Laboratory Reports        | <input type="checkbox"/> Entire Chart _____ (initial) |
| <input type="checkbox"/> Evaluation Reports        | <input type="checkbox"/> Other: _____                 |

for the following dates: \_\_\_\_\_ to \_\_\_\_\_.

The information is needed for the following purpose(s):

\_\_\_\_\_.

I understand that this consent is subject to revocation, in writing, at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be disclosed may not be made without my written consent.

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient  
if signed by parent or guardian

\_\_\_\_\_  
Parent or Guardian