Dr. Kristen Lum ND, LAc

Rivergate Natural Healthcare & Acupuncture

3750 Main Ave. Unit #1 • Durango, CO. 81301
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## AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

| | | | |
|---|---|---|---|
| **Patient Name** *(Last, First, M.I.):* | | **SSN:** | |
| **Phone** | H: | M: | W: |

| **I Hereby authorize:** | | **To Send my Medical Records to:** | |
|---|---|---|---|
| **Name of person to authorize release of information** | | **Name of person to receive information** | Dr. Kristen Lum, ND, LAc, MSOM |
| **Name of clinic/hospital/agency** | | **Name of clinic:** | Rivergate Natural Healthcare & Acupuncture |
| **Address** *(Street.):* | | **Address** *(Street.):* | 3750 Main Avenue, Unit 1 |
| *(City, State, Zip.):* | | *(City, State, Zip.):* | Durango, CO. 81301 |
| **Phone Number** | | **Phone Number** | 970.382.9100 |
| **Fax Number** | | **Fax Number** | 970.385.4187 |

**This information will be used on my behalf for the following purpose and limited to (Date and Type of Treatment):**

| | |
|---|---|
| | |
| | |

**By checking the spaces below, I authorize the release of the following medical records:**

| | | |
|---|---|---|
| ☐ **Entire medical record** | ☐ **Progress notes** | ☐ **Laboratory reports** |
| ☐ **Pathology reports** | ☐ **EKG** | ☐ **X-Ray** |
| ☐ **Operative reports** | ☐ **Other (please specify):** _____ | |

*I understand that such information can not be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for 6 months from the date of signing unless revoked earlier in writing by the patient. The only exception is when the action has already occurred as instructed in the consent.*

**Patient's or Authorized Person's Signature:**

| Patient Name (please print): | Patient Signature | Date |
|---|---|---|
| | | |

**RESPONSIBLE PARTY**: fill out if you are not the patient but are responsible for the bill.

| | | | |
|---|---|---|---|
| **Responsible Party** | | **Relationship to Patient** | |