Trailside Health
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Consent for Release of Information - from ANY source TO any

I, _____ , authorize our prior healer _____
(print your name) (your older healer)

and their authorized agents to release my medical records or designated portions thereof to my new healer:

_____
(name)

_____
(full address)

_____

_____

_____ History & Physical _____ Progress Notes _____ Laboratory Results

_____ Treatment Reports _____ Consultant Reports _____ Social Information

_____ Complete Record _____ AIDS Testing _____ Substance Use

_____ Other (Specify)_____

Signed_____ Date _____ Time _____ am/pm

Printed Name _____ Date of Birth _____

If the patient is unable to sign or is a minor, complete the following :
Patient is a minor _____ years of age or is unable to sign because_____
_____

Next of Kin or Legal Guardian _____

Witness _____

Please give this page to your prior physician...