**NOR CAL Natural Medicine**
**June E. Stevens NMD**
1135 Pine Street, Suite # 112
Redding, CA 96001
(530) 691-4115 (p)
(530) 691-4116 (f)

# Record Release Authorization

To: _____
Doctor/Hospital

Address: _____

Office #:_____ Fax #: _____

I hereby authorize and request you to release to:

June E. Stevens NMD
1135 Pine Street, Suite # 105
Redding, CA. 96001
(530) 242-8888 (Phone)
(530) 242-8889 (fax)

The Following information:

_____ Lab Only _____X-Ray/Scans Only _____Complete Medical Record

I authorize the release of photocopies of the following medical records and/or x-ray/scan files. Records or files shall include all confidential communicable disease-related information (as defined in ARS 36-661), sensitive information including HIV/AIDS/Genetic Testing, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Concerning my illness and/or treatment from _____ to _____

Name: _____ DOB:_____

Address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____