the Center
Natural Health Specialists
8404 Six Forks Rd. Suite 201, Raleigh, NC 27615
Office: (919) 848-0200 Fax: (919) 848-0211 www.TheCenterNHS.com

AUTORIZATION FOR RELEASE OF RECORDS

I, _____, hereby authorize and request
(Patient name)

_____
Name of Doctor, Clinic, Hospital, Facility

_____
Street Address

_____
City State Zip

I hereby authorize and request you to release my medical records in your possession to:

The Center: Natural Health Specialists
8404 Six Forks Road, Suite 201
Raleigh, NC 27615
office: (919) 848-0200
fax: (919) 848-2011
www.TheCenterNHS.com

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to this medical facility.

_____
Print patient or legal guardian last name and first

_____ _____
Signature of patient or legal guardian Date