AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I am Requesting Records of Doctor:

Name of facility or person:_______________________________________

Address:____

Telephone number:__________________ Fax number:_____________

THE PURPOSE FOR THIS RELEASE

> You are hereby wuthorized to furnish Dr. Cheryl Vincent information from my medical records. Please photocopy all pertinent written documents for blood test results and Diagnostic reports for NO MORE than 1-2 years previous.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance if the authorization.

I hereby release Dr. Cheryl Vincent any and all of her employees, agents managing members, and any of the attending physician(s) that I am requesting records of and/or from any and all legal responsibility or liability from the release of the above information to the extent authorized. *A copy of the authorization shall be valid as the original.*

I understand that there may be a fee for this service depending on the number of pages photocopied. If such a fee is to be paid, it shall be paid by me, the requestor and not Dr. Cheryl Vincent. However, no such fee is usually charged if these records are requested for continuing medical care.

Patient's name______________________________________

Patient's Address______________________________________

Telephone number_____________________________

Date of birth____________________

Signature_________________________________ Date_____________

Please send a copy of all records to:

Natural Whole Body Health

Dr. Cheryl Vincent D.C DABCI

540 Hopmeadow Street

Simsbury, CT 06070

Phone 860-651-3355 Fax 860-408-9648