Raina Monet Lasse

LISTEN. UNDERSTAND. HEAL.

Release of Records

Patient Name:_____Date:_____

Address:_____

Phone:_____ Date of Birth :_____

As required by the Privacy Regulations, Dr. Raina Lasse, ND may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize Dr. Raina Lasse, ND to release my records to:

By initializing the spaces below, I authorize the release of the following records from Dr. Raina Lasse, ND, if such records exist:

____ Entire Medical Record ____Progress Notes ___ Laboratory report

____Pathology reports ____EKG ____Diagnostic Imaging report

____Operative report ____ Other, Specifically:_____

This authorization will expire 180 days from the date of signing.
I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I have read and understand the Notice of Privacy Practices of Dr. Raina Lasse, ND regarding my health information and understand that I have the right to revoke this authorization in writing at any time. I understand that I do not have to sign this authorization and may request a copy of it at any time.

_____Date:_____
Signature of Patient or Authorized Representative (relationship)