



Natural Health Specialists

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

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____, [Date of Birth: _____] 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) 848-0211
www.TheCenterNHS.com

Please send: Only labs and blood work Full medical records

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