CALIFORNIA BOARD OF NATUROPATHIC MEDICINE

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • California Board of Naturopathic Medicine
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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Medical Record #:_____ Date of Death:_____
(if applicable) *(if applicable)*

Our Reference #:_____

I, the undersigned hereby authorize:

Doctor/Facility:_____

Address:_____

City/State/Zip Code:_____

Treatment Date(s):_____

to provide records in the course of my diagnosis and treatment to the ***Naturopathic Medicine Committee of California***, a healthcare regulatory agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have a right to revoke this authorization by sending written notification to the Naturopathic Medicine Committee of California at the above address. My written revocation will be effective upon receipt by the Naturopathic Medicine Committee of California but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the receipt of my information is not a health plan or health care provider and the release information may no longer be protected by federal privacy regulations.

Patient Signature: _____ Date: _____

Or Legal Representative: _____ Date: _____
(Relationship)

NOTE TO PROVIDER: Failure by a Naturopathic Doctor to provide the requested records within 15 days of receipt of this request and authorization may be construed to be a violation of the California Health and Safety Code and may result in a fine and disciplinary action.