HEALTHY BY NATURE

VITASHOT BAR • NATUROPATHIC MEDICINE • VITADRIP LOUNGE

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize the professional staff of:

_____ _____

(Name of Outside Provider) (Phone/Fax)

To disclose the following patient information to the professional staff of **Healthy By Nature**, the office of **Dr. Stacey Kupperman.**

Patient Name _____
Address: _____
Date of Birth: _____
Phone Number _____

Information to be released: ☐ faxed ☐ please mail hardcopy

☐ Complete health record
☐ History and Physical exam
☐ Labs, procedures and Images: all on file
☐ Other _____

I understand that if complete health record is checked above all medical information will be released including psychiatric records, alcohol or drug screening and HIV results.

This information is to be disclosed to :

Healthy By Nature
3535 Cahuenga Blvd, Suite 206
Los Angeles, CA 90068
P: (310) 310-9717 F: (310) 496-1779

_____ _____

Signature of Patient Date

_____

Print Name

_____ _____

Signature of Legal Guardian (if patient is under 18) Date

_____

Print Name