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Authorization to Request Protected Health Information

I, _____ (Patient Name), _____ (Date of Birth) authorize Michael D. Leu, D.Ph., N.D. to request my protected health information (PHI) from:

Individual or Company Name:	
Address:	
Phone:	
Fax:	

The following information is to be requested:

Service Period:	
Start Date:	
End Date:	
Description of records to be released (Lab results, Consultation notes, or All records)	

Patient or legal representative's signature: _____ Date: _____

Print Name: _____

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative): _____