MEDICAL INFORMATION RELEASE AUTHORIZATION

This form has been designed to ensure that confidentiality is a respected right, and to make provisions for the exchange of relevant information between service workers.

I, _____ hereby request that my:

- ☐ Healthcare Practitioner's Statement and/or prescription
- ☐ Confirmation of membership
- ☐ Confirmation of diagnosis
- ☐ Other _____

be released from _____ and forwarded to Nature's Botanicals.

This consent is valid for one time only; any additional releases of information will require my consent. Nature's Botanicals is prohibited from sharing my information without my written consent.

Patient's Name _____

Signature _____

Date _____/_____/_____ (DDMMYY)

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