noha, llc
new & old health alternatives
720-629-4211 ♦ www.noha.co

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I,____ hereby request and authorize the release of medical records to the below named practitioner(s) (hereafter noted as *noha, llc*).

Jennifer L. Davies, LAc, CMT ♦ Andrew J. Davies, CHt

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. *noha, llc* does not offer reimbursement for records received.

BIRTHDATE ____________________________________ SOCIAL SECURITY # ____

Please obtain information from the following Physician or Entity:____

Contact Information for above Physician or Entity:____

Please send my medical information to the following:

- ☐ noha, llc
  4879 South Sherman Street
  Englewood, Colorado 80113
- ☐ jennifer@noha.co
- ☐ andrew@noha.co

By checking the spaces below, I authorize the above *noha, llc* to release written records pertaining to the following information going back ___________ year(s). I also authorize *noha, llc* to provide the following information via telephone consultation:

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- ☐ Medical records needed for continuity of care
- ☐ Pathology reports
- ☐ Diagnostic imaging reports
- ☐ Laboratory reports
- ☐ Other____

PATIENT SIGNATURE____DATE______________________

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information for us by *noha, llc*. I also authorize the *noha, llc* to provide the following information via telephone consultation:

MENTAL HEALTH DIAGNOSIS, TREATMENT AND REFERRAL INFORMATION, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of the diagnosed individual.

PATIENT SIGNATURE____DATE______________________

HIV/AIDS TEST RESULTS, DIAGNOSIS, TREATMENT AND REFERRAL INFORMATION, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of the tested individual.

PATIENT SIGNATURE____DATE______________________

DRUG/ALCOHOL DIAGNOSIS, TREATMENT AND REFERRAL INFORMATION. Federal Regulation 42 CFR Part 2 requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information.

DESCRIPTION____

PATIENT SIGNATURE ____DATE______________________

Office use only: Date sent: _______________ : Sent by: __________________ Initials: _______________

Patient Name___________________________________ **Service Date**_____________________________