

Sonas Integrative Medical Center, LLC

3750 N Main Avenue #4

Durango, CO 81301

Tel: 970-247-2500 Fax: 970-247-2505

CONSENT FOR RELEASE OF INFORMATION

I, _____ DOB _____

Authorize **Sonas Integrative Medical Center, LLC**
3750 N Main Avenue #4
Durango, CO 81301
Tel: 970-247-2500 Fax: 970-247-2505

To release/receive (circle appropriate) my medical records to/from:

Practice (name, address, phone, fax) from which we will request your records

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose to third-party payers) and that in any event this consent expires automatically as described below.

I further acknowledge that the information to be released was fully explained to me and this consent is give of my own free will.

Records to be released (check all that apply): Dates: From _____ To _____

- All Records
- Health History
- Physical Forms
- Progress/Office Notes
- Labs
- X-Rays
- Consultation reports
- Diagnostic Tests: Cat Scans, MRIs, ultrasounds, EKG, etc.

Signature of Patient or Guardian

Date

Signature of Witness

Date