Medical Records Release Request

Please send records to:

Puyallup Wellness Center
Roman Krupa, ND
Laura Firetag, ND
803 39th Ave SW, Suite F Puyallup, WA 98373
TEL: 253-848-1055 | FAX: 253-848-5533

Physician **Requesting Records From**:_____

Street Address: _____

City: _____ State:_____ Zip Code:_____

Telephone: _____

Fax: _____

Dear Physician:
Kindly release diagnosis along with either a synopsis of medical history or a copy of medical records. Information regarding psychological history, HIV status or drug and alcohol treatment is also requested and authorized by the patient whose signature is below.

This authorization is limited to the following treatment: _____

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ Labs, diagnostic reports, and imaging studies.

_____ Records developed from _____ to _____.

_____ Other: _____.

_____ This authorization is limited to a worker's compensation claim for injuries for the following date:_____

Patient's Name;_____ Date of Birth: _____

Patient SSN: _____

Street Address: _____

City:_____ State:_____

Telephone #:_____

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____

Date Signature of patient/parent/guardian/personal representative