Oasis Naturopathic
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fax 623-386-0211

Consent for Disclosure of Confidential Information

Note to Client: Please do not sign this disclosure authorization unless all blanks have been completed and you have asked questions about anything on this consent which you do not understand.

Name of Patient_____
Date of Birth_____

I hereby authorize_____ to release the information requested below to Marie Santora, NMD.

Purpose of disclosure: To facilitate treatment.

Extent and nature of information to be disclosed (check those that apply)

1. _____Discharge summaries
2. _____Medical diagnosis/or evaluations
3. _____History
4. _____Treatment Plans/progress notes
5. _____Records/Lab test results, communicable diseases.

I have read the above and fully understand the consent I am about to give. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand this consent is subject to revocation by me at any time except to the extent that action has already been taken on it.

Signature of Patient_____Date_____