



Mad River Community Hospital  
3800 Janes Road  
Arcata CA 95521

**Medical Records Release for  
Full Circle Center for Integrative Medicine**

**(Practice Closure Request)**

I request the release of information regarding \_\_\_\_\_  
Patient's Name

Date of Birth: \_\_\_\_\_

**FROM:**

**FULL CIRCLE CENTER FOR INTEGRATIVE MEDICINE/MAD RIVER HOSPITAL**

**TO:**

Provider/Group/Other: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**General Records Release Policy:**

**It is our policy to release all lab and x-rays, problem and medication lists, as well as immunization records, and the encounter visit notes generated by our medical office providers.**

In the event that you are requesting fewer records be released than our normal policy of release, then please acknowledge the request below.

- Yes, Please include all records.
- Please DO NOT release information concerning:  Mental Health  HIV Status  Other \_\_\_\_\_
- Other: \_\_\_\_\_

I am enclosing \$30 for the release of my records. I understand records will not be released without payment.

This consent shall remain valid for one year from date of signature unless otherwise specified.

\_\_\_\_\_  
Date Patient, Parent, Conservator, or Guardian (Circle one)

\_\_\_\_\_  
Date Witness Signature

*The patient has the right to receive a copy of this authorization.*