Dr. Douglas R. Nichols, NMD
345 N. 2nd W. St. / P.O. Box 1073
Snowflake, AZ 85937
(928) 536-9608

AUTHORIZATION FOR RELEASE OF RECORDS

TO: _____ Telephone: _____ Fax: _____
Doctor's full name — office (include area code)

Address: _____
street — unit #

_____
city — state — zip code

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

WHITE MOUNTAIN NATUROPATHIC MEDICAL
345 N. 2ND W. ST.
SNOWFLAKE, AZ 85937
PHONE: 928.536.9608 FAX: 928.536.9611

THE FOLLOWING INFORMATION:

1) ____ Complete Health Records From:_____To:_____

2) ____ Imaging Reports (MRI, etc.) From:_____To:_____

3) ____ Laboratory Results From:_____To:_____

I authorize the release of photocopies of the following medical records and /or x-ray files. For the purpose or records or files shall include all confidential communicable disease-related information (as defined in ARS 36-3661), confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Patient's Full Name _____ Date of Birth _____
please print neatly — Month/Day/Year

Address _____
street — unit #

_____
city — state — zip code

Telephone _____ _____
home (include area code) — office (include area code)

Signature:_____ Date:_____