



Nathan M. Champion, ND

Nita J. Champion, ND

AUTHORIZATION FOR RELEASE OF RECORDS

Patient's Full Name _____ Date of Birth _____
 Address _____
 City _____ State _____ Zipcode _____
 Home Phone _____

To: (Doctor's Name or Hospital) _____
 Address _____
 City _____ State _____ Zipcode _____
 Office Phone # _____ Office Fax # _____

I AUTHORIZE YOU TO RELEASE A COPY OF:

_____ **Health Records**

_____ **Imaging Reports**

_____ **Lab Results**

Please fax to:
Partners in Healing c/o Dr. Champion at (763) 546-5754

Or mail to:
Partners in Healing c/o Dr. Champion, 10201 Wayzata Blvd., Ste. 350, Minnetonka, MN 55305

I understand that I do not have to sign this authorization. My refusal to sign will not affect my ability to receive treatment. I understand that I may revoke this authorization in writing. If I do it will not affect any actions already taken by anyone based on this authorization.

I release from you all legal responsibility or liability that may arise from this Authorization.

Signed _____
 Date _____
 Witness _____