Chelation Medical Center, LLC / Raymond Psonak D.O.
PO Box 1612, Naples, Maine 04055-1612
Phone 207-657-4325 FAX: 757-315-8052 Text: 207-926-8185

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ E-Mail: _____

Authorization:

Method of information release: [ ] mail, [ ] email, [ ] fax, [ ] phone

I, _____, hereby authorize Raymond Psonak D.O., & Chelation Medical Center LLC, to release my medical information to: (please print clearly)

Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

E-Mail: _____

NATURE OF REQUEST:
[ ] Letter to above named (explain nature of content requested below)
[ ] Phone Conversations
[ ] Lab records, [ ] Progress notes, [ ] Health Questionnaire
[ ] Complete Copy of My Medical Chart
[ ] Other (specify below)

PLEASE SPECIFY EXACTLY WHAT IS TO BE RELEASED, AND PURPOSE IF INDICATED

_____

_____

_____

_____

I understand I may revoke this authorization at any time by providing written notification to Chelation Medical Center or Dr. Psonak, PO Box 1612, Naples, ME 04055-1612.
I agree to a fee of $0.50/page for copies of my medical records, with a minimum charge of $15.00. Requests on my behalf for physician's time for preparation of special reports, research and phone conferences will be charged at $300.00 per hour in increments of 1/10 hour.

_____ _____
Signature of Patient (if 18 years of age or older) DATE

_____ _____
Signature of Parent or Guardian (if minor patient) DATE

NOTE: Proof of signature must accompany this request (i.e. copy of state I.D., passport, or notary)