Champion
naturopathic health

☐ **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:
Champion Naturopathic Health c/o Dr. Champion at **(952) 417-1913**

Or mail to:
Champion Naturopathic Health c/o Dr. Champion, 10505 Wayzata Blvd., Ste. 202, 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 understand that this authorization will expire 12 months from the date signed, unless I indicate otherwise here: _____.

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

Signed _____

Date _____

Witness _____

Champion Naturopathic Health
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