

**OpenMind Medicine
Krista Tricarico, ND**

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Authorization for Release of Medical Records

PATIENT INFORMATION (Please Print):

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Please release my medical records to:

Name _____

Phone _____

Fax _____

Please initial items below to be sent from the office of Dr. Krista Tricarico:

_____ laboratory report (please specify) _____

_____ complete medical record

_____ other (please specify) _____

By my signature, I authorize the release of my medical records.

Signature of Patient or Guardian

Date