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 ____________

Please release my medical records to:

Name ____________________________________

Address ___________________________________

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