Bridger Natural Medicine Clinic

Dr. Robert Lemley, ND NCMP
1043 Stoneridge Drive, Suite 1
Bozeman, MT 59718 Phone: 406.585.0205 Fax: 406.585.0207

I hereby authorize:

____

Name of person to authorize release of info

____

Name of Clinic/Hospital/Agency

____

Street Address

____

City State Zip Code

____

Fax

To send my medical records to:

Robert Lemley, ND, NCMP

Name of person to receive info

Bridger Natural Medicine Clinic, LLC

Name of Clinic/Hospital/Agency

1043 Stoneridge Drive, Suite 1

Street Address

Bozeman, MT 59718

City State Zip Code

Fax #: (406)585-0207

Patient Information:

____

Patient Name D.O.B.

____

SSN Phone Number

____

Street Address

____

City State Zip

I authorize the release of the following specific confidential information:

______ Lab Results (Specify)

____

______ Health Records (Specify)

____

______ X-ray Reports

______ X-rays

______ Other (Specify)

I hereby consent to release the above information, including alcohol, drug abuse and mental health records obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for six months from the date of signing unless revoked in writing earlier. The only exception is when the action has already occurred as instructed in the consent.

X ______________________________ ______________________ ______________________

Signature: (Patient, guardian, legal rep) Date Relation to Patient

I understand that a variety of tests have been undertaken and one of them may have been an HIV-related test. My signature below authorizes release of any test results including any HIV-related (AIDS) test results.

X ______________________________ Date: ______________________________