Chelation Medical Center, LLC / Raymond Psonak D.O.
255 Intervale Road, New Gloucester, Maine 04260
Phone: 207-657-4325 FAX: 207-517-2619

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, 255 Intervale Rd, New Gloucester, ME 04260.
I understand that there may be a charge of up to $0.50/page for copies of my medical records. A fee for physician's time for preparation of special reports, research and phone conferences of $210.00 per hour in increments of 1/10 hour may be charged.

_____ _____
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)