# ECLECTIC NATUROPATHIC MEDICAL CENTER, LLC

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## Permission/Request for Sharing Private Health Information

I, _____, request that a copy of my medical records, including labs and clinical notes from:

Doctor's Name: _____

Address: _____

_____

Dated from: _____ to _____

**Be released to the above Practitioner by fax or mail**

Patient Name (please print): _____

Signature: _____

Date: _____