Eclectic Naturopathic Medical Center, LLC

Kathleen M. Riley, N.D.

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Permission Request Form

I give permission to Dr. Riley or Dr. Lugo to contact my current Medical Health Care Physician(s) to discuss my medical records, including labs and clinical notes.

Patient Signature: _____Date: _____

Please list Physician(s) names and phone number(s)

Doctor's Name	***Phone Number***
Doctor's Name	***Phone Number***
Doctor's Name	***Phone Number***
Doctor's Name	***Phone Number***
Doctor's Name	***Phone Number***