



**PRIMARY CARE ALTERNATIVE MEDICINE P.A.**

Dr. Sarah Kotzur, ND

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**MEDICAL INFORMATION RELEASE AUTHORIZATION**

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This form requests the release of medical information to 'Primary Care Alternative Medicine, P.A.'

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**PATIENT INFORMATION**

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Name: .....

Date of Birth: .....

Address: .....

Telephone or Email: .....

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**PLEASE SEND THE INFORMATION MARKED BELOW**

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- Complete medical record - including chart notes, labs and imaging studies.
- Labs only.
- Imaging Studies only.
- Specify: .....

**Please mail records to:**  
Primary Care Alternative Medicine, P.A.  
142 High Street, Suite 305  
Portland, ME 04101

**Please fax records to:**  
(207) 699-4198

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**DECLARATION**

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I, .....

authorize the release of my medical records to **Primary Care Alternative Medicine, P.A.** I ask that the above records be sent on my behalf.

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Signature

Date