Consent For the Release of Medical Records
Christina M. Jackson, L.Ac., and Associates, P.S.

I give my permission for Christina M. Jackson, L.Ac. to release the following medical information to:_____

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I give my permission for _____ to release the following medical information to Christina M. Jackson L.Ac:

____Any medical records including information on HIV/AIDs and chemical dependency

____Only the following:
_____
_____

____To discuss my case with the above provider by phone or email or in person

The release shall be in force for a period of one year from the signing unless otherwise noted.

Date_____

Patient signature_____

Guardian/parent signature_____

Records can be faxed to 425-557-0595