AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Legal Name _____ Date of Birth _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____

- I hereby authorize release of my medical records ? TO or ? FROM (current physician's name and contact information)

_____

To disclose protected health information of the person listed above ? TO or ? FROM

? Daniel Rubin, ND, FABNO ? Lise Alschuler, ND, FABNO ? Melissa Coats, ND
? Jessica Stefanski, ND, LAc, MAc ? Amy Waite, ND ? Debi Smolinski, ND
? Damon Tallcouch, ND ? Walter Crinnion, ND

Naturopathic Specialists. LLC

FAX 480.990.1110

- Reason to release protected health information: _____

- Type of access requested (copies of the records):
  - ? Entire record ? Nursing notes ? ER records
  - ? Imaging/radiology ? History and physical ? Consult reports
  - ? Operative reports ? Rehabilitation services ? Immunizations
  - ? Laboratory reports ? Cardiac studies ? Demographics
  - ? Progress notes ? Physician's orders
  - ? Medication records ? Other_____

- I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that there may be a fee involved with the fulfillment of this request.
- I understand that the term, entire record, regarding release of protected Health Information means that only records generated by the named facility will be released.
- I have read the above and authorize the disclosure of the protected health information.

Date _____

Signature of Patient/Parent/Legal Guardian _____

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