integrativehealth
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A FRESH APPROACH TO LIVING WELL

Records Release Authorization

Patient

Name ______________________ DOB ____ / ____ / ____

Address ______________________

City ______________ State ______ Zip ______

◯ Records to be sent from Doctor/Clinic below and delivered to IHC.
◯ Records to be sent from IHC to Doctor/Clinic/Person/Group below:

Doctor/Clinic/Other ______________________

Address ______________________

City ______________ State ______ Zip ______

Phone ______________ Fax ______________

I HEREBY authorize the release of the following medical records TO/FROM Integrative Health as listed above. Records shall include all confidential communicable disease-related information (as defined in ARS 36-3661), confidential alcohol or drug abuse information, and confidential mental health diagnosis and treatment information. I hereby release you, the physician, and your employees from any and all liability for fulfilling this authorization request. This consent will expire one year after the signed date below. A facsimile or copy of this authorization is considered acceptable in lieu of the original.

Please mail or fax the last two years of selected records:

◯ Lab Imaging ◯ Reports Consult Notes ◯ Summary

◯ Complete Medical Records ◯ Stat

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Patient Signature (or legal guardian if applicable) Date