



AUTHORIZATION FOR RELEASE OF INFORMATION
(Release must be filled out completely in order for records to be released.)

To: _____
(Doctor/Hospital)

Address: _____

Office #: _____ Fax #: _____

I hereby authorize the above healthcare provider to disclose any and all parts of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus („HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness, (except for psychotherapy notes) chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Print Patient

Date of Birth

Social Security Number

Description of information to be released: Any and all documents for the time frame listed below.

All _____ OR 2 Years _____ OR 5 Years _____ OR Time Frame: From _____ To _____

If no option is selected 2 years of medical information will be released

The health information described shall be released TO:

Women's Health and Healing Center
8362 East Florentine Road, Suite C
Prescott Valley, AZ 86314
Phone: 928-515-2363
Fax: 480-999-5585

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until

Expiration event/ date

I understand that I may revoke this authorization at any time by notifying my physician in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ Date _____
Signature of Patient

Patient phone: _____

Patient address: _____

If you are not the patient:

*What is your relationship to the patient? _____

*If you are the patient’s healthcare decision maker, please provide a **Medical Power of Attorney**.

*If the patient is deceased and you are the personal representative of the patient’s estate, please attach evidence (e.g. Death Certificate).

IT IS UNDERSTOOD THAT THERE MAY BE A FEE FOR OBTAINING THESE RECORDS.