Julie Flynn, ND · Organic Health Institute · Gilbert, AZ 85297

Medical Release Form

Authorization for release of patient information:

I______________________ hereby authorize my healthcare provider to disclose any and all parts of my identifiable health information as described below, which may include but is not limited to, laboratory test results, medical history, treatment, as well as, communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, alcohol or drug dependency, and other related information regarding my health.

In signing this document, I understand this authorization is completely voluntary, and I may refuse to sign this medical release authorization document if I choose. Furthermore, I understand that if I choose *not* to sign this document, it will in no way affect the health care I receive or the payment of the payment of the health care.

I understand that if the recipient authorized to receive the information is not a covered entity (covered by insurance or health care provider) the released information may no longer be protected by federal and state privacy regulations.

____________________________________ _____________________ _______-______-_______

Patient name (print) **Date of Birth** **Social Security Number**

___________________________ ____

Patient phone number **Patient address**

Description of the information requested and authorized to be released: check what applies*

_____ *any and all* documents pertaining to health information, including but not limited to: medical history, lab results, and treatment
_____ medical history and treatment only for past 2 years

If no option is selected, the first option ("any and all documents pertaining to health information, including but not limited to: medical history, lab results, imaging, and treatment") will be released

Purpose of use and or disclosure: at the request of the individual

Health information described for________________________, shall be released TO:

___

Name Address City State Zip

I desire this authorization to be in effect until: ________________, otherwise it will expire in 90 days.
Expiration event/date

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

____ ________________
Patient signature Date

If you are not the patient:
Print your name: ____
Your relationship to the patient: ____

If you are the primary decision maker regarding the patient's health care, please provide a Medical Power of Attorney.
If the patient is deceased and you represent the patient's estate, you must attach evidence (ie death certificate)