**Natural Choice Healthcare**
10505 N 69th St #1100A,
Scottsdale, AZ 85253

# AUTHORIZATION TO RELEASE MEDICAL RECORDS NCH

*This document must be written, dated, and signed by the patient or a legally-authorized person.*

Patient Legal Name: * _____

Date of Birth: * _____

## I authorize the following practitioner / office to release medical records on my behalf:

Name, address, and phone number of clinic/provider authorized to release medical records: * _____

_____

_____

_____

Please release a copy of the medical information specified below to:

**Natural Choice Healthcare**
**Dr Tom Jemison**
**10505 N 69th St #1100A Scottsdale, AZ 85253**
**480-420-3254**
**FAX: 602-325-1220**

Requested time period: Last 12 months or Dates of Service: *

☐ Last 12 months ☐ Dates of Service: _____

This information will be used on my behalf for continuity of care.

I specifically authorize the release of the following medical records and personal health information, if such records exist for: *

☐ All hospital records
☐ Records needed for continuity of care
☐ Emergency and Urgent care records
☐ Clinician office chart notes
☐ Laboratory reports
☐ Pathology reports
☐ Diagnostic imaging reports
☐ Entire medical record
☐ Others _____

INITIALS: _____

The following items require a specific authorization and must be acknowledged to be included in the use or disclosure of other medical information

HIV/AIDS test or result information and/or records ☐ Yes ☐ No

Mental health information and/or records

Genetic testing information and/or records *

INITIALS: _____

I have reviewed and understand this authorization. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

☐ Yes ☐ No

INITIALS: _____

You do not have to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services.

The only circumstance where refusal to sign means you will not receive care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing on (insert applicable date or event).

INITIALS: _____

**PATIENT SIGNATURE or legal representative :** _____

Date _____

Print name of person signing this form (and relationship, if other than patient) * _____