Naturopathic Health Solutions, LLC

Authorization for Release of Records

(Complete one per physician)

Patient Name: ____ DOB: ______________

Address: ____________________________________ City/St/Zip: ________________________

Home# ____________________________ Cell# _________________________________

Requesting records release from the following physician:

Physician's Name: _________________________________ Specialty: __________________________________

Office #: _________________________ Fax #: _______________________

Please send Chart notes / diagnostic & lab reports for **the previous 12 months**

Release the above information to: **(fax is preferred method)**

Naturopathic Health Solutions, LLC Office #: (480) 656 - 2119

Mail to: 8010 E. MCDOWELL RD., SUITE 105, SCOTTSDALE, AZ 85257

Fax to: **(480) 656 - 2368**

Attention: Dr. Elaine Burns/ Medical Director

Records released for the purpose of: **Concurrent Care**

☐ **NEW PATIENT** ☐ **EXISTING PATIENT**

[Internal Office Note: ☐ Add to chart no other action Required OR ☐ Patient of Dr. _____________ On Hold]

I authorize the provider to use or disclose information related to: AIDS/HIV and other Communicable Diseases, Genetic Testing Information, Psychiatric Care Reports, Alcohol and/or Drug Abuse Treatment.

I have given my consent freely, and without coercion. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original. This consent expires on year after the signed date below.

__________________________________ ____________

Patient or legal representative Signature Date

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Print Name