EVND
east valley naturopathic doctors

Authorization to Release Medical Information

Patient Name: _____ DOB: _____

Patient Phone: _____

Patient Signature: _____

Relation to Patient: _____ Date: _____

I authorize my medical information to be released from:

Physician's Name: _____

Name of Facility: _____

Phone: _____ Fax: _____

PLEASE FAX MY RECORDS TO:

DOCTOR: _____

EAST VALLEY NATUROPATHIC DOCTORS

5416 E. SOUTHERN AVE., STE 110, MESA, AZ 85206

PHONE: 480.985.0000 FAX: 480.985.0029

TYPE OF INFORMATION TO BE RELEASED:

☐ GENERAL MEDICAL RECORDS, excluding protected records (copies of medical records will be limited to the past two years unless otherwise specified, and including labs and imaging reports.

SPECIFIC INFORMATION ONLY (Specify dates: _____)

☐ History & Physical ☐ Medications & Therapy

☐ Labs, Pathology Reports, EKG, Imaging Reports (Specify type: _____)

☐ Operative Report ☐ Injury/Accident Report

☐ Other: _____

PRIVACY DISCLAIMER:

The information transmitted is intended solely for the person or entity to whom it is addressed. Any review, retransmission, dissemination, or other use of this information by persons or entities other than to whom it is addressed is prohibited.