# Medical Records Release Form

Patient Name _____ Birthdate _____

Address_____
_____

Phone number _____

I hereby authorize the named provider to disclose 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, chemical or alcohol dependency, laboratory test results, medical history treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Physician Name _____ Physician phone number_____

Physician Address_____

Fax Number_____

To the following provider:

Garden Of Health, llc
Jane Hendricks NMD
Phone: 480-535-7868
**Fax: 480-265-4387**
drjanenmd@yahoo.com

- I understand that this authorization will expire 180 days from the date of this authorization unless I otherwise specify by date or an event.
- I further understand that I may revoke this authorization at any time by notifying Garden Of Health, LLC. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.
- I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic Tests and x-rays covering the following dates of service:_____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Patient signature_____ Date_____