



Records Release Authorization

Name: _____ Date of Birth: _____
Address: _____

- I hereby authorize the release of all medical records.
- Or
- I hereby authorize the release of only the following records:
- Laboratory
 - Progress
 - History and Physical
 - X-Ray and Other Diagnostic
 - Other

I UNDERSTAND THAT THE FOLLOWING INFORMATION **WILL NOT BE RELEASED UNLESS INITIALED**. I CONSENT TO AND AUTHORIZE YOU TO RELEASE THE FOLLOWING RECORDS THAT I HAVE **INITIALED**.

- Sexually Transmitted Disease
- HIV Testing
- Substance Abuse
- Mental Health

Information to be released BY:

Physicians Name and Clinic

Address

City State Zip

Phone Fax

Information to be released To:
East-West Integrated Healthcare
42323 N. Vision Way, Ste 108
Anthem, AZ 85086

Phone: 623-551-0027

Fax: 623-551-1768

Patient Signature

Date

Signature of Parent or Legal Guardian (Minor)

Relationship to Patient

Witness

This Release Expires after 90 Days.

I understand that I do not have to sign this document in order to receive health benefits. I may revoke this in writing. I understand that once the health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.