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ARIZONA INTEGRATIVE MEDICAL SOLUTIONS
Achieve Your Health Aims

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Tempe, AZ 85282

Authorization For Release of Medical Records

Doctor/Hospital:_____

Address:_____

Office #:_____**Fax**:_____

Please release the following records:

_____**Lab Date(s)**_____

_____**Imaging Date(s):**_____

_____**Complete Medical Records Date(s)**_____

I specifically authorize the release of all medical information relating to the below-named patient including by not limited to the following categories protected by state or federal law: 1) substance abuse (drug or alcohol) treatment; 2) mental health treatment; 3) HIV-AIDS related information, if such information is contained in the records. This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider or another entity.

Thank You For Prompt Return of Records!

Patient Name:_____

Parent/Guardian:_____

Address:_____

_____

DOB:_____

Signature:_____Date:_____

This authorization will remain in effect until one year from the date of the signature above, unless another date is specified as noted here: _____ You may revoke this authorization at any time by providing our office with written notice.