AUTHORIZATION TO RELEASE MEDICAL INFORMATION

IRIE Natural Center for Health
6625 S. Rural Rd. #103
Tempe, AZ 85283
Phone: (480) 341-9400 Fax: 623-321-0219

I. Patient Information

Name:_____ Date of Birth: _____
Address: _____ Phone:_____
City/State:_____

II. Release Information

Information to be released from: _____
Name & Address of Facility Provider: _____
Phone/Fax#: _____
Information to be released to:

Sonya M. Johnson, N.D.
6625 S. Rural Rd. #103
Tempe, AZ 85283
Phone: (480) 341-9400 Fax: 623-321-0219

Information to be released:
☑Most recent progress note □Last 2 years □Last 3 years □Last 5 years □Complete records
□Medical Records for the following dates: _____
□Other(e.g. imaging and Lab reports): _____

Reason for the release:
□Personal □Doctor□Attorney □Insurance □other_____

III. Patient Rights

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at IRIE Natural Health Center. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

I authorize the release of the following medical records and/or imaging files. Records or files shall include all confidential communicable disease-related information (as define in ARS 36-661), confidential alcohol or drug abuse related information and confidential mental health diagnosis/treatment information.

The Authorization expires: _____ (if left unsigned, then 1 year from the date of this Authorization)

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship