Aurora Natural Medicine

3651 E Baseline Rd. Ste E-121
(480) 719-5119

Authorization for Release of Protected Health Information Records

Patient Legal Name _____ Date of Birth_____

Address _____ Phone #_____

City _____ State _____ Zip Code _____

I hereby authorize:

Aurora Natural Medicine
3651 E. Baseline Rd. Ste E-121
Gilbert, AZ 85234
(480) 719-5119

Check one:

▫ To disclose the protected health information of the person listed above to: (No charge if records can be faxed):

Doctor's full name:_____

Phone number: _____

Fax number: _____

OR

▫ Send a hard copy of records to myself at the address listed above.

- ▫ I have included a $10 payment for records handling and postage (Required)

Initial below (Required)

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

_____ I have read the above and authorize the disclosure of the protected health information.

Printed Name: _____

Signature: _____ Date: _____