NATUROPATHIC SPECIALISTS. LLC

Authorization for Release of Protected Health Information Records

Patient Legal Name _____ Date of Birth _____ SSN _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____

- I hereby authorize (your **current** Doctor's full name, address and phone number)

_____

To disclose protected health information of the person listed above to (check one):

☐ **Daniel Rubin, ND, FABNO** ☐ **Lise Alschuler, ND, FABNO**

☐ **Marianne Marchese, ND** ☐ **Debi Smolinski, ND**

Naturopathic Specialists. LLC
7331 E Osborn Dr # 330
Scottsdale, AZ 85251

- Reason to release protected health information:

- Type of access requested (copies of the records):

☐ **Entire record**	☐ Nursing notes	☐ ER records
☐ **Imaging/radiology**	☐ History and physical	☐ Consult reports
☐ **Operative reports**	☐ Rehabilitation services	☐ Immunizations
☐ **Laboratory reports**	☐ Cardiac studies	☐ Demographics
☐ **Progress notes**	☐ Physician's orders	
☐ **Medication records**	☐ Other_____	

- I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that there may be a fee involved with the fulfillment of this request.
- I understand that the term, ***entire record***, regarding release of protected Health Information means that only records generated by the named facility will be released.
- I have read the above and authorize the disclosure of the protected health information.

Date _____

Signature of Patient/Parent/Legal Guardian _____