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**
- ☐ **Meilssa Coats, ND**
- ☐ **Leila Turner, 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**
  - ☐ **Imaging/radiology**
  - ☐ **Operative reports**
  - ☐ **Laboratory reports**
  - ☐ **Progress notes**
  - ☐ **Medication records**
  - ☐ Nursing notes
  - ☐ History and physical
  - ☐ Rehabilitation services
  - ☐ Cardiac studies
  - ☐ Physician's orders
  - ☐ Other_____
  - ☐ ER records
  - ☐ Consult reports
  - ☐ Immunizations
  - ☐ Demographics

- 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 _____