REQUEST FOR MEDICAL RECORDS

THIS DOCUMENT PROVIDES YOUR AUTHORIZATION FOR PRIOR DOCTORS AND AGENCIES TO RELEASE YOUR PREVIOUS MEDICAL RECORDS TO DR MCCANN

PATIENT INFORMATION

Name_____
Date of Birth_____
Address _____
_____
City, State, Zip _____
Phone _____

I hereby authorize the release of the following patient medical records:

_____All Medical Records
_____Other _____

INFORMATION TO BE RELEASED

Sign next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information
Yes_____ No_____

Mental Health Information
Yes_____ No_____

AIDS/HIV Testing & Results
Yes_____ No_____

Sexually Transmitted Diseases Test/Results
Yes_____ No_____

Communicable Diseases
Yes _____ No_____

Genetic Testing
Yes_____ No_____

and is limited to the time period
from_____
to_____

TO BE RELEASED FROM

Doctor or Agency_____
Address _____
_____
City, State, Zip _____
Phone _____
Fax_____

TO BE RELEASED TO

Rachael O'Connell, NMD
2030 W Baseline Rd
Ste 182126
Phoenix AZ 85041
Phone: (714) 594-9542
Fax: (480) 546-3986

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

My signature below indicates I give my authorization to release my medical information as indicated.

_____
Print Patient's Name

_____
Patient's Signature or Signature of Legal Guardian, if applicable Date