10900 N. Scottsdale Road, Suite 303
Scottsdale, AZ 85254

Records Release Authorization

PATIENT

Name ______________________________ DOB _____ / _____ / _____
Address ____
Phone _____-_____-______ City ______________ State _____ Zip ______

RECORDS TO BE OBTAINED FROM

Doctor/Clinic ______________________________________
Address ____
City ______________________________ State ________ Zip ______
Phone _____-_____-______ Fax _____-_____-______

I authorize the release of the following medical records and/or x-rays. Records or files shall include all confidential communicable disease-related information (as defined in ARS 36-3661), confidential alcohol or drug abuse information, and confidential mental health diagnosis and treatment information.

THE FOLLOWING
- ☐ Lab only
- ☐ X-Ray only
- ☐ Complete Medical Records

CONCERNING
- ☐ All Treatment
- ☐ Treatment from _____ / _____ / _____ to _____ / _____ / _____

I hereby authorize the release of the above-noted medical records to:

Aletris Center of Integrative Medicine
10900 N. Scottsdale Road, Suite 303
Scottsdale, AZ 85254

telephone **480 443 7168**
facsimile **480 948 1367**

______________________________ ______________
Patient Signature **Date**