Records Release Authorization

Name: _____ Date of Birth: _____
Address: _____

- ❑ I hereby authorize the release of only the following records:

  - ❑ Laboratory
  - ❑ Progress
  - ❑ History and Physical
  - ❑ X-Ray and Other Diagnostic
  - ❑ Other

I UNDERSTAND THAT THE FOLLOWING INFORMATION **WILL NOT** BE RELEASED UNLESS **INITIALED**. I CONSENT TO AND AUTHORIZE YOU TO RELEASE THE FOLLOWING RECORDS THAT I HAVE **INITIALED**.

- ❑ Sexually Transmitted Disease
- ❑ HIV Testing
- ❑ Substance Abuse
- ❑ Mental Health

Information to be released By:

_____
Physicians Name and Clinic

_____
Address

_____
City State Zip

_____
Phone Fax

Information to be released To:
Calvo Naturopathic Healthcare
Jennifer Gentry, NMD
42104 N Venture Dr Ste B122
Anthem, AZ 85086

Phone: 623-251-5518
Fax: 623-249-4748
Email: Assistant@DrJenGentry.com
(preferred method if electronic records are available.)

_____
Patient Signature Date

_____
Signature of Parent or Legal Guardian (Minor) Relationship to Patient

_____
Witness

This Release Expires after 90 Days.

I understand that I do not have to sign this document in order to receive health benefits. I may revoke this in writing. I understand that once the health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.