Dr. Jenna Dye
naturopathic physician

Records Release Authorization

Patient Name: _____ DOB ____/____/____

Address: _____
City, State Zip

Phone: ____-____-____

Physician & Clinic: _____
Doctor Practice Name

Address _____
City, State Zip

Phone: ____-____-____ Fax: ____-____-____

Disclose my medical information to the following provider:

Dr. Jenna Dye, Naturopathic Physician
10221 N. 32nd St Suite G
Phoenix, AZ 85028
P: 480-448-8888 **F: 844-391-7650**

I authorize the release of the following records:

- ☐ Lab – *most recent ONLY*
- ☐ Lab / pathology reports – *last 6 months*
- ☐ Lab reports – *last 1 year*
- ☐ Complete medical record (*dates*) _____ *to* _____
- ☐ Imaging reports – *last 6 months*
- ☐ Imaging reports – *last 1 year*
- ☐ Most recent Mammogram ONLY

* The following items must be INITIALED to be included in the records to be released:

_____ HIV/AIDS related records
_____ Drug/Alcohol diagnosis, treatment or referral information.
_____ Mental health records
_____ Genetic testing information

As required by the Privacy Regulations, Dr. Jenna Dye may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1) Revoke this authorization by sending written notice to this office. I also understand that revocation will not affect the office's previous reliance on the authorization provided.
2) Refuse to sign this authorization
3) Receive a copy of this authorization
4) Restrict what is disclosed with this authorization
5) I also understand that if I do not sign this document, it will not condition my treatment, payment, or eligibility for benefits whether or not I provide authorization to sue or disclose protected health information.

_____ _____/_____/_____
Signature of Patient or Patient's Authorized Representative (relationship) *Date*