



INTEGRATIVE MENTAL HEALTH
CENTER

I hereby authorize the release of information from the medical record of:

Patient Name: _____

Date of Birth: _____ Patient Phone Number: _____

I understand that the information to be released is for the purposes specified below. Any other use without the patient's consent is prohibited. I further understand that I may revoke this consent at any time. Unless otherwise specified below, this authorization is valid for 180 days from the date that it was signed. By signing below, I authorize and request the release of my medical information between the following practitioners:

<p>Practitioner #1: <input type="checkbox"/> Nicole Cain, ND <input type="checkbox"/> Tara Peyman, ND 11000 N. Scottsdale Rd. Ste. 230, Scottsdale, AZ, 85254 P. 480-426-8040 Fax: 1-844-518-2558</p> <p>Check all that apply: <input type="checkbox"/> Send records to this practitioner <input type="checkbox"/> Send records from this practitioner <input type="checkbox"/> Authorize communication between practitioners without sending records</p>	<p>Practitioner #2: Practitioner: _____ Phone: _____ Fax: _____ Address: _____ _____ _____</p>
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Please release the following medical information:

from the following date range: _____
 from all date ranges send all records
 Initial intake notes Progress notes History/Physical Exam
 Labs Imaging/EKG reports Medication list
 Other: _____

Include information (if applicable) pertaining to:

Mental health Drug/Alcohol history HIV status Communicable disease status

Purpose of Need for Disclosure:

Coordination of care Attorney/Legal Disability information
 Other: _____

I authorize release of my medical records between the above practitioners for the following period of time, beyond 180 days (6 months):

1 year 2 years 3 years other: _____
 I prefer for this authorization to have no expiration

Patient/Guardian Signature: _____

Today's Date: _____

CONFIDENTIALITY NOTICE:

This transmission is intended only for the addressee shown above. It may contain information that is privileged, confidential or otherwise protected from disclosure. Any review, dissemination or use of this transmission or any of its contents by persons other than the addressee is strictly prohibited. If you received this document in error, please call us immediately upon receipt and return the documents to the address below.