AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting Records of Doctor

NAME OF FACILITY OR PERSON: _____

ADDRESS: _____ CITY/ST/ZIP: _____

PHONE NUMBER: _____ FAX NUMBER: _____

THE PURPOSE FOR THIS RELEASE:

You are herby authorized to furnish & release to: **TRANSFORMATIONAL MEDICINE,** all information from my medical/psychological, and other health records, with no limitations placed on history of illness or diagnostic or therapeutic information, including furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information. I further authorize release of the following information if it is contained in those records:

Labs only: Yes No
Imaging Reports: Yes No
Alcohol or Drug Abuse: Yes No
Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes No
Genetic Testing: Yes No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This Authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.
I hereby release **TRANSFORMATIONAL MEDICINE and Dr. DeeAnn Saber**; from legal responsibility or liability for the release of my medical records to the extent authorized. A copy of this authorization shall be valid as the original.
I understand there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continued medical care.

Patients Name: _____ DOB: _____

Signature: _____ Date: _____

Please send any/all records to:
Dr. DeeAnn Saber, NMD
2028 E. Prince Road, Tucson, AZ 85719
Office:**520-209-1755** Fax: **520-798-2468**