

# ALETRIS

CENTER of INTEGRATIVE MEDICINE

## 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/Imaging only
- Complete Medical Records

NO handwritten progress notes please!

#### CONCERNING

- All Treatment
- Treatment from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

**Aletris Center of Integrative Medicine, Inc.**  
7425 E Shea Boulevard, Suite 111  
Scottsdale, AZ 85260

telephone (480) 998 2020

facsimile (480) 948 1367

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date