Choose Physician/Specialty

 Dr. Christine Brass-Jones OB/GYN
 MaryAnn Shostek PA-C
 Dr. Denise Grobe ND

Authorization for Release of Medical Information

In accordance with legal and regulatory agency requirements, the health record is the property of Center for True Harmony Wellness & Medicine™ PC. We waive all fees for copying current year labs/imaging released to a patient and copying patient records sent to a Physician/Medical Facility. All other requests will be charged a fee of $25, and we will fulfill your request when the fee is paid. This form must be completed in its entirety in order for us to process your request.
I hereby authorize the release of information from the medical record of:

Patient Name:___________________________________Date of Birth:______________

Telephone #_________________________

Address_________________________________City, State, ZipCode________________

***Information Released:*** TO FROM (circle one)
Center for True Harmony Wellness & Medicine™ PC
2152 S Vineyard #138, Mesa AZ 85210
480-539-6646 P; 480-539-6696 Fx

***Information Released:*** TO FROM (circle one)
Name:_________________________________________
_________________________________________
Address:___________________________________
_________________________________________
Phone:_____________________________________
Fax:_______________________________________

***Please release:***
□ All Records, □ Pt Intake forms and Previous Medical History Forms □ Current Year Lab/Imaging Reports____________
□ All Lab/Imaging Reports____________□Only the following__________________________

***This information is necessary for the following purpose:***
□Changing Physicians □Personal Use □ Attorney/Legal □ Insurance
□ Other (*specify)*__________________________________________________

***How would you like the information released?***
*(Circle one)* Mail(mailing fee applies) Fax Pickup

***Informed Consent for Release of Confidential Information:***

- I may revoke this consent in writing at anytime except to the extent actions have already been taken.
- This consent will expire 180 days after the date of my signature unless otherwise specified.
- That there is a fee for copy services rendered
- That the information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment and test results.
- That the information released is for the specific purpose stated above.
- That my medical records may contain reports only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold Center for True Harmony Wellness & Medicine™ PC or any staff members/practitioner/physician liable for any misinterpretation of the information in my medical record as a result of not consulting my physician/practitioner for the correct interpretation.
- That the payment of the above fee is due prior to my record release and that within fifteen (15) days of receipt of payment, my records will be available.
- Center for True Harmony Wellness & Medicine™ PC is require to comply with Federal HIPPA regulations concerning medical privacy, and that IU may view the office policy at any time

Signature of Patient or legal representative:____________________________________________________________

Date_________________________Relationship to Patient________________________________________________