AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____
Date

To: _____ Fax: _____

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

I, _____, hereby authorize **THRIVE LIFE CENTER** to receive information from the above named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of _____. I understand that this authorization will expire in 30 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy rule.

Specific records being requested: _____

_____

I acknowledge that my records may include sensitive material. Therefore, I request that you include the following records, if any (initial by categories to be <u>included</u> in records provided):

___Substance Abuse ___AIDS/HIV/STDs ___Psychological/Psychiatric Conditions ___Genetic Testing

Please send the requested information to:

THRIVE LIFE CENTER
1102 W. Ina Road 85704
Phone: (520) 261-9808
Fax: (520) 526-9922

_____ _____
Signature of Patient or Legal Guardian Relationship