Dr. Bruce A. Sadilek
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# REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO ANOTHER PHYSICIAN OR REQUEST FOR A PERSONAL USE COPY

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by written notice.

Please print clearly:

PATIENT NAME: _____ DOB: _____/_____/_____

RECORDS RELEASED FROM:: Bruce A. Sadilek, N.M.D.
Integrative Medical Associates
7468 N. La Cholla Blvd Phone (520) 297-9664
Tucson, AZ 85741 Fax (520) 297-9633

RECORDS TO BE SENT TO:
DOCTOR'S NAME OR PATIENT'S NAME* _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____
Please select: ☐MAIL ☐FAX ☐ PICKUP

*It is the policy of Integrative Medical Associates to charge for the processing of medical records relating to purposes **other than** continuing care (personal use), along with requiring pre-payment of these fees. This is in accordance with ARS 12.2295, A., which states that except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records a reasonable fee for the production of the records and may require the payment of any fees in advance. Our fees are set at $25.00 professional fee plus $1.00 per page up to 50 pages, and $.50 per page thereafter.

The patient referenced above has agreed to the release of the following medical information indicated below.

☐ Medical Diagnostic / Problem List ☐ Office and Surgical Reports ☐ Lab & X-ray Results

Period of Time: ☐ Last 12 months only ☐ Entire Records ☐ Other _____

In addition to the general authorization to release records, I may authorize the release of the following information:

| DRUG/ALCOHOL ABUSE | MENTAL HEALTH | HIV/AIDS |
|---|---|---|
| _____Yes | _____Yes | _____Yes |
| _____No | _____No | _____No |

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE SIGNED.

SIGNATURE:_____ DATE:_____
Signature of patient or patient's representative

NAME:_____RELATIONSHIP:_____ DATE:_____
Printed name of patient's representative and relation to patient

FOR OFFICE USE ONLY

$_____FEE CASH VISA MASTERCARD CHECK #_____

_____/_____/_____RECEIVED _____/_____/_____PROCESSED _____PROCESSED BY (initials)

NOTES:_____