Dr. Bruce A. Sadilek
7468 N. La Cholla Blvd.
Tucson, AZ 85741
(520) 297-9664 fax (520) 297-9633
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REQUEST FOR AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This form is submitted on behalf of our mutual patient. This is not a notification for transferring care.

Please print clearly:

PATIENT NAME: ____ DOB: _______/_________/______

TO: Bruce A. Sadilek, N.M.D.
Integrative Medical Associates
7468 N. La Cholla Blvd
Tucson, AZ 85741

Phone (520) 297-9664
Fax (520) 297-9633

FROM:

DOCTOR'S NAME: ____

ADDRESS: ____

CITY: ________________________ STATE: ___________ ZIP: ___________________

PHONE: ______________________________ FAX: ___________________________

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

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.

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

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FOR OFFICE USE ONLY

Faxed on ______________ By ___________________ Confirmed of receipt on _________________ By _____________

Notes:____

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