

# Dramov Naturopathic Medical Center - Arizona

36600 N Pima Road, #307  
480-442-8999

CAREFREE, AZ 85377  
FAX 877-365-3958

## AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization

I \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ authorize  
(name of patient) (Date of Birth) (Social Security#)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Name of hospital/health care provider) (Phone number) (Fax number)

to release a copy of medical information to:

**Dr. Rob Dramov, ND**  
**36600 N PIMA ROAD, #307**  
**CAREFREE, AZ 85377**

**Phone: 480-442-8999 / Fax: 877-365-3958**

This information will be used on my behalf for the following purposes: \_\_\_\_\_

I hereby release the following medical records:

- |   |  |
|---|--|
| <input type="checkbox"/> Please send entire medical records               | <input type="checkbox"/> Diagnostic imaging reports    |
| <input type="checkbox"/> All hospital records                             | <input type="checkbox"/> Most recent five year history |
| <input type="checkbox"/> Medical records necessary for continuity of care | <input type="checkbox"/> Pathology reports             |
| <input type="checkbox"/> Laboratory reports/results                       | <input type="checkbox"/> Clinician office chart notes  |
| <input type="checkbox"/> Other: _____                                     |  |

The following require the initials of the patient to be released:

- |  |  |
|--|--|
| <input type="checkbox"/> HIV/AIDS related records    | <input type="checkbox"/> Mental health information                                 |
| <input type="checkbox"/> Genetic testing information | <input type="checkbox"/> Drug/Alcohol diagnosis, treatment or referral information |

This authorization is limited to:

Following treatments: \_\_\_\_\_ Following time period: \_\_\_\_\_

\*\*\*\*\*Please call us ahead of time if fax is more than 30 pages. Thank you\*\*\*\*\*

**Right to terminate or revoke authorization:** *this authorization may be revoked at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.*

**Potential for re-disclosure:** *information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.*

**Rights of the individual:** *you may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization.*

Name of Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of patient or legal guardian)

Relationship of Representative to Patient: \_\_\_\_\_