Keystone
NATURAL FAMILY MEDICINE

Authorization for Release of Protected Health Information Records

Patient Legal Name _____Date of Birth_____

Address_____ Phone #_____

City_____ State_____ Zip Code_____

□ I hereby authorize (your current Doctor's full name, address and phone number)_____
_____
_____

To disclose protected health information of the person listed above to (check one):

_____Dr. Kristen Bishop _____ Dr. Jorge Reveron
_____ Dr. Samantha Randahl _____ Dr. Robyn Wright

Keystone Natural Family Medicine
10153 East Hampton
Suite 104
Mesa, AZ 85209
(480) 535-5688

PLEASE FAX RECORDS TO (888) 866-6737

** IF MORE THAN 15 PAGES PLEASE MAIL**

Type of access requested (copies of the records):
_____ Entire record from _____
_____ Lab work
_____ Imaging
_____ Other_____

□ I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
□ I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Legal Representative_____
Date:_____