Medicine Woman

Dr. Mihrage Willhauck, NMD
2230 S. Saratoga
Mesa, AZ 85202
P: 602-842-1770

Medical Records Release Form

Patient First and Last Name _____

Patient Date of Birth _____

Patient Email Address _____

Patient Phone Number _____

I hereby authorize:

Clinic Name: _____

Clinic Phone: _____

Clinic Fax: _____

To release information to:

Medicine Woman
Dr. Mihrage Willhauck, NMD

Fax: 855-635-7732

INFORMATION TO BE RELEASED

☐ Complete Medical Records
☐ Lab reports/documents/imaging from the past year
☐ Provider notes, labs, and treatment plans from the last appointment
☐ Other (specify content and dates): _____

_____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- I understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.

_____ _____

Signature of patient, parent of minor, or personal representative Date

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION