Living Wellness
MEDICAL CENTER

CONSENT TO RECEIVE AND OR RELEASE CONFIDENTIAL INFORMATION

Patient First and Last Name ______________________ Patient Date of Birth ______________________

Patient Address ______________________ City ______________________ State ______________________ Zip ______________________

Patient Phone Number ______________________ Patient Email: ______________________

I hereby authorize:	**To release my medical records to:**
Longevity Medical Health Center / Chambers Clinic 13832 N 32nd St #126 Phoenix, AZ 85032 (602) 899-4070 (602) 493-2159 (Fax)	Marianne Marchese, ND Living Wellness Medical Center 4440 N 36th St. #110 Phoenix, AZ 85018 480-588-6856 480-307-6019 (Fax) FrontDesk@LivingWellnessMedicalCenter.com

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): ______________________

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ACKNOWLEDGEMENT OF UNDERSTANDING:

- 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 re-disclosure by the recipient and no longer be protected by federal privacy regulations.
- I understand that there may be a fee involved with the fulfillment of this request.
- 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.
- I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that there may be a fee involved with the fulfillment of this request.
- I understand that the term, entire record, regarding release of protected Health Information means that only records generated by the named facility will be released.
- I have read the above and authorize the disclosure of the protected health information.

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