



**TREE OF LIFE NATURAL MEDICINE**  
**Dr. Andrew J. Kaufmann, ND, PLC**  
**459 N. Gilbert Road, Suite A-135 Gilbert, AZ 85234**  
**Phone (480) 840-1841 \* Fax (480) 840-1596**

## Authorization to Release Medical Information

1. I AUTHORIZE:

\_\_\_\_\_  
 Name of sending person/organization

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City State Zip Code

2. TO RELEASE TO:

\_\_\_\_\_  
 Name of receiving person/health care provider

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City State Zip Code

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

- All Information       All Progress Notes       Lab Reports       X-ray Reports  
 Electrocardiogram (ECG)       Allergy Records       Immunization Records       Other: \_\_\_\_\_

**SPECIAL AUTHORIZATION:** Check applicable box(es) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:

- Alcohol       Drugs       Mental Health       Sexually Transmitted Diseases       HIV       AIDS

**Note:** If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

4. **RECORDS FROM THE TIME PERIOD:**    /    /    through    /    / \_\_\_\_\_

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

- Continued Medical Care       Payment of Insurance Claim       Legal  
 Personal       Workers' Compensation Claim       Other: \_\_\_\_\_

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_