

Green Leaf Clinic Authorization for Release of Records (Complete one per physician)

Patient Name: _____ DOB: _____

Address: _____ City/St/Zip: _____

Home# _____ Cell# _____

Requesting records release from the following physician:

Physician's Name: _____ Specialty: _____

City/State _____

Office #: _____ Fax #: _____

Please check which types of records you are requesting:

☒ Past 1-3 Visit Summaries (including intake notes, diagnoses, treatments & medications)

☐ Imaging / Radiology Reports (please do not send film)

☐ Surgery / Biopsy Reports

Date Range _____ to _____

Release the above information to:

Green Leaf Clinic
1989 W Elliot Rd Ste 29
Chandler, AZ 85224
Office #: (480) 656-1068
Fax #: (855) 831-5119

Attention: Patient Coordinator

Records released for the purpose of: Concurrent Care

I authorize the provider to use or disclose information related to: AIDS/HIV and other Communicable Diseases, Genetic Testing Information, Psychiatric Care Reports, Alcohol and/or Drug Abuse Treatment. I have given my consent freely, and without coercion. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original. This consent expires on year after the signed date below.

_____ Patient / Legal Representative Signature

_____ Date