MONARCH
HEALTH & WELLNESS

3335 E Indian School Rd.
Suite 150-H
Phoenix, AZ 85018

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name _____ Date of Birth _____

Phone (Home) _____ Phone (Cell) _____

Address _____

City _____ State _____ ZIP _____

PLEASE NOTE: Retrieval and copy fees will be charged for Medical Records

ABOVE LISTED CLIENT AUTHORIZES THE FOLLOWING HEALTHCARE FACILITY TO MAKE RECORD DISCLOSURE:

☐ Monarch Health and Wellness LLC
3335 E Indian School Rd. Ste. 150H
Phoenix, AZ 85018
FAX: 949-863-6864

or

☐ Name _____
Address _____
City _____ State ___ ZIP _____
Fax _____

	The purpose of disclosure is:		
☐	Collaboration of Treatment Care	☐	Referral
☐	Change of Insurance or Provider	☐	Other

	Dates and type of information to disclose:		
☐	All dates of medical records	☐	Specific information requested
☐	Dates Other ~ *from:* *to:*		

Information Released (please check one of the following):

☐ Verbal ONLY ☐ Written ONLY ☐ Both Verbal and Written

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

Authorized Recipient (to whom the information will be provided):

Release to _____

Address _____

City _____ State _____ Zip Code _____

Fax _____ Phone _____

	Records to be released:
	Please mail records to address provided for recipient
	Please have records available for pickup at the front office

MONARCH OFFICE USE ONLY	
Monarch Personnel Signature	
Date Records Provided	

I understand that signing this authorization is voluntary. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION**. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Monarch Health and Wellness LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date:

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature _____ Date _____
or Authorized Representative
(Guardian or Authorized Representative MUST attach documentation of such status)

Printed Name of Authorized Representative _____

Address of Authorized Representative _____

Relationship/Capacity to patient _____

Phone number of Authorized Representative _____