I hereby authorize the release of information from the medical record of:

Patient Name: _____

Date of Birth: _____ Patient Phone Number: _____

I understand that the information to be released is for the purposes specified below. Any other use without the patient's consent is prohibited. I further understand that I may revoke this consent at any time. Unless otherwise specified below, this authorization is valid for 180 days from the date that it was signed. By signing below, I authorize and request the release of my medical information between the following practitioners:

Practitioner #1:	**Practitioner #2:**
___Diane Grise, ND 4535 S. Lakeshore Dr., Ste. 2 Tempe, AZ 85282 P. 602-551-7055 **Fax: 1-844-693-2325** **Check all that apply:** **__ Send records to Dr. Grise.** **__ Send records from Dr. Grise.** **__ Authorize communication between practitioners without sending records**	Practitioner: _____ Phone: _____ Fax: _____ Address: _____ _____ _____

Please release the following medical information:

__ from the following date range: _____

__ from all date ranges **__ send all records**

__Initial intake notes __Progress notes __History/Physical Exam

__Labs __Imaging/EKG reports __Medication list

Other: _____

Include information (if applicable) pertaining to:

__Mental health __Drug/Alcohol history __HIV status __Communicable disease status

Purpose of Need for Disclosure:

__Coordination of care __Attorney/Legal __Disability information

Other: _____

I authorize release of my medical records between the above practitioners for the following period of time, beyond 180 days (6 months):

__ 1 year __ 2 years __ 3 years __ other: _____

__ I prefer for this authorization to have no expiration

Patient/Guardian Signature: _____

Today's Date: _____