AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME_________________________________BIRTHDATE____________

ADDRESS____

CITY, STATE, ZIP____

PHONE_________________________

I consent to the release of my medical records as follows:

_____All Records _____Labs _____Other________________________________

TO: (Doctor/Institution)	**From: (Doctor/Institution)**
Physician:	Dr. Kyle Neeley
Clinic:	The Wellness Clinic
Address:	2272 E. Speedway Blvd. Tucson, AZ 85719
Phone:	Phone: 520-326-9355
Fax:	Fax: 520-795-1445

In addition to the general authorization to release medical records, I further authorize release of the following information if it is contained in my records:

Drug and alcohol abuse	Yes	No
Mental Health	Yes	No
Diagnosis or treatment of HIV, HIV related illness, AIDS, AIDS related illness and communicable disease related information	Yes	No

PATIENT SIGNATURE___________________________________DATE___________