TRUE HARMONY
WOMEN'S HEALTHCARE FOR LIFE

Authorization for Release of Medical Information

In accordance with legal and regulatory agency requirements, the health record is the property of True Harmony. We waive all fees for copying current year labs/imaging released to a patient and copying patient records sent to a Physician/Medical Facility. All other requests will be charged a fee of $25, and we will fulfill your request when the fee is paid. This form must be completed in its entirety in order for us to process your request. I hereby authorize the release of information from the medical record of:

Patient Name (First, Middle, Last) Email DOB

Patient Address City State Zip Code Phone Number (Cell | Home)

Information Released: TO | FROM (circle one)

Physician Name

Chandler Office: 1727 W Frye Rd, Suite 140
Chandler, AZ 85224
480-605-2200 Phone
833-428-2241 Fax

Information Released: TO | FROM (circle one)

Doctor / Clinic Name

Street Address

City State Zip Code

Phone Fax

Please release:

☐ All Records ☐ Pt Intake forms and Previous Medical History Forms ☐ Current Year Lab / Imaging Reports
☐ All Lab / Imaging Reports ☐ Only the Following

This information is necessary for the following purpose:

☐ Changing Physicians ☐ Personal Use ☐ Attorney/Legal ☐ Insurance
☐ Other (specify)

This information is necessary for the following purpose: ☐ Fax ☐ Pickup ☐ Mail (mailing fee applies)

Informed Consent for Release of Confidential Information

- I understand that I may revoke this consent in writing at any time, except to the extent that actions have already been taken based on this authorization.
- This consent will expire 180 days after the date of my signature unless otherwise specified.
- A fee will be charged for copy services rendered. Payment of this fee is required prior to the release of records. Within fifteen (15) days of receipt of payment, my records will be made available.
- The information released may include sensitive material such as HIV/AIDS status, mental health information, chemical dependency diagnoses, treatment, and test results.
- The information is being released only for the specific purpose stated above.
- I acknowledge that my medical records may contain reports or entries that only a licensed physician can accurately interpret.
- I have been advised to consult directly with my physician regarding the contents of my medical records to avoid misinterpretation.
- I agree not to hold True Harmony or any staff member, practitioner, or physician liable for any misunderstanding or misinterpretation of my medical records if I fail to consult with my physician for proper explanation.
- I understand that True Harmony is required to comply with Federal HIPAA regulations regarding medical privacy. I may view the office privacy policy at any time.

Signature of Patient or Legal Representative Relationship to Patient Date