TUMBLEWEEDS HEALTH CENTER

PATIENT RELEASE OF MEDICAL RECORDS

Patient Name Phone # DOB

_____

Doctor's Name Phone # Fax #

_____

I authorize my medical information to be released and faxed to the offices of Tumbleweeds Health Center for any or all of the following:

Dr. George Huggins, MD
Dr. Guy Petersen, MD
Dr. Nancy Aton, NMD
Dr. Joshua Reilly, NMD

Information to be disclosed (circle all that apply):

Most recent 3 progress reports
HIV/AIDS Information
Drugs/Alcohol
Behavioral Health
Sensitive Information

I release the parties listed above from any liability associated with the release of confidential medical information in accordance with this authorization.

Patient Signature_____

Date_____

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TumbleweedsHealthCenter.com