TUMBLEWEEDS HEALTH CENTER

PATIENT RELEASE OF MEDICAL RECORDS

Patient 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. Aiyana Brown, NMD

Information to be disclosed (circle all that apply):

HIV/AIDS Information

Behavioral Health

Most recent 3 progress reports

Radiology Reports

Drugs/Alcohol

Sensitive Information

Lab Results

Complete Record

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

Pt Signature_____ Date_____

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