Dyer Health PLLC Mailing Address: 1645 W. Valencia Rd., Suite 109, Box 220, Tucson, AZ 85746 Phone: 1-520-888-3032; Permanent Phone: 1-520-595-3457 Fax: 1-520-293-1566

Patient Request to Receive Copies of Medical Records

PATIENT NAME: ____

DOB: _______________________ SS # ____________________________

PATIENT RECORDS FROM Practice Office: Dyer Health PLLC, 2001 West Orange Grove Road, Suite 416, Tucson, AZ 85704

I hereby authorize and request the release of the following information:

_____ ALL PATIENT INFORMATION

_____ PATIENT INFORMATION FOR VISIT DATE(S) __________ TO ___________

_____ OTHER (specify) ____

____

PATIENT RECORDS TO: SELF or Guardian

I understand that once the healthcare provider provides the information that I am requesting to be released, the healthcare provider has no control over the information provided to me or by me to Third Parties. The individual or organization that I share the information with might redisclose it or fail to ensure the information remains confidential and federal or state privacy laws may no longer protect the information. I agree that Dyer Health PLLC is released from any and all liability or responsibility regarding information released to me, by me, or to Third Parties pursuant to Patient's Authorization to release such information.

This Authorization is valid for one year from the date of signature, and a copy of this Authorization is as valid as an original. If information is sent directly to other providers, as a courtesy, no service fee will be charged. In accordance with the State of Arizona, if the records request is from a patient to obtain healthcare, no fee will be charged.

Signature: ____

Date: ______________________________

Relationship to patient (SELF or Guardian): _____________________________