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 Send Medical Records To Other Provider

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: _____

Facility/ Physician Name _____

Address _____

City, State Zip _____

Telephone Number/Fax Number _____

I understand that once the healthcare provider provides the information that I am authorizing and requesting to be released to Third Parties, the healthcare provider has no control over the information provided to Patient or Third Parties. The individual or organization that I authorized to receive the information 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 Patient or 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. There is no fee to send medical records to other providers.

Signature: _____

Date: _____

Relationship to patient (if parent or guardian): _____