

Authorization to Release Confidential Health Information/Medical Records

I Hereby Authorize:

- Thrive Wellness MD LLC / Dr. Yousef Mohammadi, MD
- Facility/Doctor Name: _____
_____ Address: _____
_____ City: _____
_____ State: _____ Zip: _____
_____ Phone #: _____ Fax #: _____

To Release the following:

- Complete Chart Record *(does not include billing information or radiographic images)*
- Chart Notes: All Specify: _____
- Labs/Reports: All Specify: _____
- Other: Specify: _____

Please check below if you do not want to include any of the following sensitive information relating to:

- HIV/AIDs Mental Health Records Substance Abuse Genetic Testing Information

From the Health Records of the following Patient:

Patient Name: _____ Date of Birth: _____
Address: _____ Daytime Phone #: _____
Are you authorizing release of your own records? Yes No
If not, what is your relationship to the patient? _____

**Release of certain medical information requires a minor's consent. This applies to information pertaining to substance abuse, mental health information, pregnancy, and sexually transmitted diseases, including HIV and AIDS. Other laws may apply depending upon the patient's state.*

To be Released to:

- Thrive Wellness MD LLC / Dr. Yousef Mohammadi, MD
Mailing Address: 15825 N 71st street Apt 656, Scottsdale, Arizona, 85254
Email: Drmohammadi@thrivewellnessmd.care
Phone: (602) 345-0323
- Facility/Doctor/Other: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax#: _____

- I understand that unless revoked, this authorization is valid for 90 days from the date of signing.
- I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law.
- I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

Signature of Patient/Legal Representative

Date

Patient Name (print)

Representative Name/Relationship to Patient