Desert River Solutions

Authorization for Release of Medical Records

Patient Name____

Address____

Phone____________________________________

Date of Birth_________________________ Last Four of Social Security__________________

Requesting From (Old Doctor Name):___________________________________

I authorize Desert River Solutions to SEND medical records to the following and by the following option:

( ) Email Secured downloadable link to email below(Fastest)

OR

( ) Mail Encrypted Thumb Drive to Below Address

Send to(Name):____

Address____

City_____________________State________Zip____________________

Email____(PRINT LEDGIBLY)

___I do ___ do not authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

I authorize the release of an electronic version of my medical records in the possession or control of the above named provider/clinic/hospital; its employees and agents.

****$25.00 charge Needs to be paid before release of records**

____ ______________________

Patient/Legal Representative Signature Date

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Relationship to Patient

Questions/Concerns: requests@DesertRiverSolutions.com or 480-577-3150/ **Expect 5-10 Business Days for requests**