Desert Naturopathic Health

Medical Records Release

This is to be filled out by the patient and sent to the patient's physician in order to release records to Dr. Jensen.

Patient Name: ___________________________________ DOB: __________________

I authorize: ____

To release a copy of my medical records to:

Dr. Jason W. Jensen, NMD
Desert Naturopathic Health, LLC
20045 N 19th Ave, Ste 166
Phoenix, AZ
P – (602) 888-1201
F – (602) 288-0124

For the purpose of:

Please disclose medical records from (date) __________________________ to

Including: Lab X-Ray Office Notes H&P

If applicable, the undersigned further authorizes his/her doctor to disclose a copy of records pertaining to:

- Testing and/or treatment for AIDS and AIDS related diseases
- Treatment of psychiatric illness
- Treatment for drug and or alcohol abuse.

Signature of Patient/Guardian_________________________________ Date: ___________

Address ____

City, State, Zip ____

Desert Naturopathic Health, LLC 20045 N 19th Ave, Suite 166 Phoenix, AZ 85027
Phone: (602) 888-1201 Fax: (602) 926-0180
www.DesertNaturalHealth.com