Office Use Only
Date received: _____
Provider initials: _____
Date sent/via:_____
Staff initials: _____

PURPLESAGE
A Healthy Lifestyle Center

Purple Sage Center, Inc.
1420 East Northern Ave.
Phoenix, AZ 85020
602 . 938 . 8200 (P)
602 . 938 . 8519 (F)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient/Client Name:_____
First MI Last Previous Name

Address:_____

Date of Birth: _____ Phone: _____

Release Records		Release Records
From: Karsten Alexandria, N.D., P.C.		**To:** Karsten Alexandria, N.D., P.C.
To:		**From**:
_____ Name of Facility Doctor	**OR**	_____ Name of Facility Doctor
_____ Address		_____ Address
_____ City State Zip		_____ City State Zip
_____ Phone Fax		_____ Phone Fax

Records to be released for the purpose of:

☐ **Concurrent Care** ☐ **Transfer of Care** ☐ **Other:** _____

IMPORTANT – You may NOT disclose health care information regarding testing, diagnosis, and treatment for the following:
- ❒ HIV (AIDS virus)
- ❒ Sexually transmitted diseases
- ❒ Psychiatric disorders/mental health
- ❒ Drug and/or alcohol use

Information to be released (be specific):
- ❒ Last 2 years of records
- ❒ Last 5 years of records
- ❒ Imaging reports (type & date) _____
- ❒ Dates of service from _____ to _____
- ❒ Other (specify) _____

This authorization expires within 90 days of being signed. If you wish to have the authorization expire before 90 days please indicate the date of expiration: _____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
- To take part in a research study, or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization by writing a letter to Karsten Alexandria, N.D., Purple Sage Center, Inc. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Unless specifically excluded, this authorization includes release of specially protected information requiring specific written consent. This includes referral, diagnosis and treatment related to substance abuse, mental health conditions and sexually transmitted diseases including HIV. Release of certain information also requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases and HIV/AIDS.

_____ _____ _____
Patient or legally authorized individual signature **Date** **Printed name**