Rejenesis Health | Kevin Chan, DO, MS, MMM, PCEO, FASA, FAIHM
3196 N. Windsong Drive | Prescott Valley, AZ 86314
Phone: 928-772-1505 | Fax: 928-772-6343

Authorization for Disclosure of Health Information

Please REQUEST Medical Information FROM:	Please SEND Medical Information TO:
_____ *Name of Health Care Provider*	Rejenesis Health *Name of Person or Entity to Receive*
_____ *Street Address*	3196 NORTH WINDSONG DRIVE *Street Address*
_____ *City, State, and Zip Code*	PRESCOTT VALLEY, AZ 86314 *City, State, and Zip Code*
_____ *Phone/Fax*	(928) 772-1505/ (928) 772-6343 *Phone/Fax*

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Patient Name: _____ Date of Birth: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosed party. Written revocation will not affect any action take in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless is specifically required or permitted by law.

This includes all confidential information, including communicable disease information, HIV-related information, alcohol or drug abuse related information, and mental health diagnosis and treatment information. I wish these records to be forwarded as soon as possible.

*I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only*_____

_____

A copy of this authorization is valid as an original. I have a right to receive a copy of this authorization. The copy is for me to keep.

Patient's Signature: _____ Date: _____
(or patients parent or legal guardian)

Patient's Address: _____