Lovick Natural Medicine and Wellness

(602) 834-0494
(480) 428-4251 fax
www.drlovick.com

Medical Records Release

_____

Patient Legal Name Date of Birth

_____

Address Phone #

_____

City State Zip

I hereby authorize the release of all protected health information of the person listed above to
Dr. Ann Lovick
Lovick Natural Medicine and Wellness
(602) 834-0494
(480) 428-4251 fax

Please mail or fax the last two years of selected records:

- Lab imaging
- Reports/Consult Notes
- Summary Complete
- Medical Records

I acknowledge that records shall include all communicable disease-related information (as defined in ARS 36-3661), confidential alcohol or drug abuse information, and confidential mental health diagnosis and treatment information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
I understand that there may be a fee involved with the fulfillment of this request. I have read the above and authorize the disclosure of the protected health information.

_____

Signature of Patient/Parent/Legal Guardian Date