Independent Wellness Center

1000 W. Apache Trl #108

Apache Junction, AZ 85120

Office #:480-983-5060 Fax #: 480-983-5070

To:_____

Address:_____

Office #:_____Fax#_____

I Hereby authorize and request you to release to:

Independent Wellness Center

The Following Information:

_____Lab Only

_____X-Ray

_____Complete medical Records

From_____To_____

I authorize the release of photocopies of the following medical records. Records or files shall include all confidential communicable disease-related information (as defined in ARS 36-661), confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Sign_____ Print_____

D.O.B_____ Date_____