14122 W McDowell Rd STE 102-B Goodyear, AZ 85392 Office: 623-236-8720 FAX:623-234-9682

Soluna Holsitic Healthcare, INC.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION:

Name: ____ **Date of Birth:** ___________________________

Address: ____ **City/Zip:** __________________________________

Main Phone:________________________________

I request and authorize ____ to release healthcare information of the patient to:

Name: ____

Information to be released:

☐ All Medical Records (including records relating to mental healthcare, HIV)

☐ Certain Dates: ____________________ From ____________________ To

☐ All dates of care

☐ Omit History of STD, HIV, Mental health testing, treatment for alcohol or drug abuse, and/or diagnosis.

This medical information may be used by the person I authorize to receive this information for medical treatmentor consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force and effect until _______________ (date or event), at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient or Patient Representative Signature: ____

Date: ___________________