



Authorization to Transfer Legacy Practice Records

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAHP

Patient and Legacy Source

I am a former patient of Dr. Gear, Payson Health and Wellness, Comprehensive Health Services, or 4 Health and Wellness.

I authorize the transfer or copying of my complete medical record / complete patient file, as available, from:

- ☐ Dr. Robert Gear, Jr.
- ☐ Payson Health and Wellness
- ☐ Comprehensive Health Services
- ☐ 4 Health and Wellness

I understand that some legacy records may be stored in historical paper files to which Dr. Weyrich has physical access or control, even though the original practices or organizations may no longer be operating.

Authorization and Scope of Transfer

I authorize Dr. Weyrich and his practice to locate, access, copy, transfer, scan, index, maintain, and use my complete available legacy medical record / complete patient file from the legacy sources checked above.

I understand that these legacy records may be historical paper files from defunct practices and may not be organized in a way that allows Dr. Weyrich to reliably identify, separate, exclude, or specially handle particular categories of information. This authorization is intended to allow transfer of the complete available legacy medical record / complete patient file as maintained.

Note: Records may no longer be available. Arizona record-retention requirements vary by provider type, patient age, and applicable law, and some legacy records may have been lawfully destroyed or may no longer be retrievable.

Limitations and Special Handling

I may request a specific written limitation below, but Dr. Weyrich is not required to accept or implement a limitation that he determines is not reasonably feasible, is legally uncertain, or would require disproportionate review or segregation of legacy records.

If a requested limitation, legal restriction, or special-handling issue prevents a complete transfer from being performed reasonably and lawfully, Dr. Weyrich may decline the transfer entirely and may decline or limit any service that depends on those records.

Specific limitation requested, if any:

- ☐ No limitation requested; transfer the complete available legacy record as maintained.
- ☐ Limitation requested: _____

I understand that Dr. Weyrich generally may not require me to sign this authorization as a condition of treatment, payment, enrollment, or eligibility for benefits, except to the extent that a requested service cannot reasonably be performed without the legacy records needed for that service.

Release records to

Orville R. Weyrich, Jr., PhD, NMD, BCN, ABAHP

Secure Email: DrWeyrich@Hushmail.com

Mailing Address: 10208 E. San Salvador Dr, Scottsdale AZ 85258

FAX: (888) 595-3582

Purpose

☐ Continuity of care ☐ Case Integration Review ☐ At my (patient) request

☐ Other: _____

Expiration and Required Notices

Information disclosed under this authorization may be redisclosed by the recipient as permitted or required by applicable law and may no longer be subject to the same privacy requirements, including any HIPAA requirements that applied to the original custodian.

This authorization expires whichever comes first: one year from signature, when the requested transfer is completed, or when revoked by me in writing, except to the extent that action has already been taken in reliance on it.

Patient / Representative Signature

Patient Legal Name (printed):

(First)_____ (Middle)_____ (Last)_____ (Suffix) _____

Date of Birth: ____ / ____ / ____

Legal guardian or authorized representative, if applicable (printed):

(First)_____ (Middle)_____ (Last)_____ (Suffix) _____

Relationship _____ Authority to sign _____

Signer is: ☐ Patient ☐ Legal guardian ☐ Authorized representative

Signature _____ Date ____ / ____ / ____

Practice determination if limitation or special-handling issue is present

- ☐ Complete transfer accepted
- ☐ Limitation accepted as reasonably feasible
- ☐ Limitation not accepted; transfer declined unless revised authorization is obtained
- ☐ Legal/special-handling issue identified; transfer paused or declined pending review

Determination by: _____ **Date** ____/____/____

Practice use only:

Received by _____ **Date** ____/____/____

Disposition _____ **Date** ____/____/____