1355 E. Higley Road, Suite 113, Gilbert AZ 85296

Phone: (480) 988-2181 Fax: (480) 907-1167

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Patient Name:______________________________________ DOB:___________________

Address:____

Phone: ____

Send Records to:____

Address: ____

Phone:_____________________________ Fax:_____________________________________

WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE:

______All Healthcare Information

______X-Ray/MRI/CT reports

______Laboratory tests, Diagnostic Test Reports

Specific Healthcare Information relating to the following treatment or condition:

____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, genetic testing, HIV results or AIDS information. I hereby request and authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed/faxed/emailed to above doctor/facility at the indicated address for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and protected health information. I expect the holder of my medical records to mail/fax/email my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment. I understand there may be a fee involved with the fulfillment of this request.

Request Records From: ____

Address:____

Phone:______________________________ Fax: ____________________________________

I have read the above and authorize the disclosure of the protected information.

Patient Signature:____Date:_______________

Parent/Guardian/POA Signature:_______________________________Date:_______________

PLEASE RETURN RECORDS WITH THIS AS COVER PAGE!
THANK YOU!