AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(FROM)

Patient Name: _____ Medical Account #: _____

Patient Address: _____

Patient Phone: _____ Date of Birth _____ SSN: _____

Please REQUEST medical information from: Desert Grove Family Medical Group
840 E. McKellips #101
Mesa, AZ 85203
Phone (480) 834-7546 Fax (480) 833-8313

Please SEND the medical information to: _____
Name of person or entity to receive the information

Address: _____

City, State, Zipcode _____ Phone #: _____

Purpose of Disclosure:

_____ Continued patient care _____Insurance coverage or payment for care _____ At Patient's Request

_____Other (please explain) _____

Duration: This authorization is effective immediately and shall remain in effect for one year from the date of this signature unless another date is entered here _____.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to when the release of information takes place. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Redisclosure: I understand that the requester may not lawfully further disclose the health information unless they obtain another authorization from me or unless the disclosure is specifically required or permitted by law.

Specify the Records to be Released/Disclosed:

_____**General Medical Information**—This will include progress notes, call logs, referrals, consultations from specialists and any other general information included in your chart.

_____**Laboratory Results and/or X-Ray reports**

_____**Information Regarding Specific Injury or Treatment (From _____ To _____)**

(Initials are required on all the remaining if you wish for them to be released)

_____ **AIDS/HIV and any other Communicable Disease**

_____ **Behavioral Health/Psychiatric Care**

_____ **Alcohol/Drug Abuse Treatment**

_____ **Other** _____

I understand all the matters discussed on this form. I release the provider, employees, business associates and directors from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I understand that I have a right to receive a copy of this authorization and I will request it if I want one.

[ ] I would like the records to be on a CD for $25.00 [ ] I would like the records to be copied to paper for $35.00

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (only if patient is minor or incapacitated) Relationship to Patient