AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Please send paper records as we DO NOT ACCEPT CDs

RELEASE RECORDS FROM: ____

Address: ____

Phone: ______________________________ Fax: ______________________________

I authorize the above named to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

________________________________ ______________________ ____________________
Print Patient Name Date of Birth Social Security Number

Release **ALL** my health information for the **PAST YEAR**, unless otherwise specified:****PLEASE DO NOT FAX RECORDS IF OVER 25 PAGES.****
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The reason or purpose of the use and/or disclosure: ____

The health information described herin ***SHALL BE RELEASED TO***:__________________________

____

Phone: ___________________________________ Fax:______________________________

RECORDS MAY ALSO BE FAXED TO: (480) 924-4140 Attention: Medical Records

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify by date or by an event. I desire this authorization to be in effect until _______________.

I further understand that I may revoke this authorization at any time by notifying either party in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

____ ____________________________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient's Representative

____ OR ____
Relationship to Patient Legal Authority (attach supporting documentation)

Skyline Family Medicine 6112 E. Brown Rd. Mesa, AZ 85205 ph (480) 924-4422 fax (480) 924-4140