



AUTHORIZATION TO RELEASE RECORDS

DATE: _____

TO : _____
(Doctor / Hospital)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Phone/Fax: _____

I hereby authorize to release and send photocopies of my medical records

To ___ From ___ the following doctor/facility/persons:

_____ John D. Marshall, M.D.	_____ Adam L. Schwartz, P.A.-C
_____ George L. Sibley, M.D.	_____ Daniel D. Smith, D.C.
_____ Angela Calderon, P.A.-C	_____ (Other) _____

I hereby authorize the release of copies of any and all medical records including any and all diagnostic reports that are in your possession. For the purposes hereof, "Medical Records" shall include all confidential HIV related information (as defined in A.R.S. 36-661), confidential communicable disease related information (as defined in A.R.S. 36-661), confidential alcohol or drug abuse related information (as defined in 42 CFR Sec 2.1 ET SEQ), and confidential mental health diagnosis/treatment information unless otherwise specified by you not to be included per HIPAA guidelines.

Information to be sent: (check one)

All Medical Record(s) _____ Medical Records Specify _____

This consent will expire (60) sixty days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Paradise Valley Family Care, and its specific provider in writing to that effect. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____	_____	_____
Printed Patient Name	Social Security Number	Date-of-Birth
_____	_____	_____
Patient Signature	Parent/Guardian Representative	Date