NORTH PHOENIX INTERNAL MEDICINE

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Phone: (602) 589-0370 Fax: (602) 589-0650

I authorize _____ to disclose Protected Health Information (PHI) from the health records of:

Patient's Name: _____

Date of Birth: _____

Address: _____

Social Security Number: _____

SEND RECORDS TO:

North Phoenix Internal Medicine

1747 E. Morten Ave., Suite 303 Phoenix, Arizona 85020 or Fax to (602) 589-0650

Information to be Disclosed: (Please Mark)

- ❑ All Records (Progress Notes, Labs, X-rays, Hospitalization, etc...)
- ❑ Other (Specify Information): _____

Purpose of the Disclosure: (Please Mark)

- ❑ Continuation of Care
- ❑ Primary Care Physician or Insurance Changed
- ❑ Disclosure at Patient's Request
- ❑ Other (Specify): _____

I authorize the Provider to use or disclosure of Information related to my Health and I consent to release of Information created within 12 months after the Date of this Authorization was signed.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand that the Clinic/Hospital or Doctor's office will not condition treatment on my signing this Authorization. The Clinic/Hospital or Doctor's office will not deny me treatment if I do not wish to sign this form. I may refuse to sign this Authorization Form. I understand that I may revoke this Authorization at any time. I must submit a written request for Medical Records unless I revoke this Authorization earlier; It will be expired one (1) year from the Date of Signature. I understand that if this Information is disclosed to a Third party, the Information may no longer be protected by the Federal Privacy Regulation and maybe disclosed by the Person/Organization of the received Information. I understand that the matters discussed on this form. I release the Providers, it's Employees, Officers, and Directors, Medical Staff Members, and Business Associates from any Legal responsibility or Liability for the Disclosure of the above Information to extent indicated and the Authorization here in.

Patient's Name (Print): _____ **Witness:** _____

Patient's Signature: _____ **Date:** _____