GILBERT FAMILY MEDICINE, LLC

Authorization for release of Medical Information

Patient's Full Name:_____

Date of Birth: ___/_____/_____ Social Security #: _____/_____/_____

Address:_____

_____

I authorize the release of photocopies of the following information from:

_____

_____

Phone: _____

Fax: _____

_____ Medical Records of the past Two (2) Years of Treatment

_____ All HIV and/or Communicable Disease related information

_____ Conditions related to psychiatric and/or psychological treatment

_____ Conditions related to drug and/or alcohol abuse (federal Regulation 42 CFR Part 2)

_____ Other:_____

This information is needed for the following purpose (s): _____

_____

To release the information specified above to:

Gilbert Family Medicine
1760 E. Boston St. Suite 101
Gilbert, AZ 85295
P: 480-355-8180
F: 480-355-8844

I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Gilbert Family Medicine, LLC in writing to that effect. I understand that a release that was made prior to my revocation in accordance 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.

Patient/Guardian Signature: _____ Date: _____

If signed by a Guardian, relationship to Patient: _____

Witness: _____

Patient was unable to sign due to: _____

There is NO CHARGE when records are sent to a physician for continuing care. A copying fee is charged when records are released to a patient or other non-physician recipients.

Form #04 Rev: 01/2005