## GILBERT FAMILY MEDICINE, LLC

Authorization for release of Medical Information

Date of Birth:/	Patient's Full	Name:		
I authorize the release of photocopies of the following information from:    Phone:	Date of Birth:	/Socia	l Security #:/	/
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:  Witness:  Witness:	Address:			
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	If signed by a	Guardian, relationship to Patient:		
Patient was unable to sign due to:	Witness:			
	Patient was u	nable 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