CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

☐ **3638 E. Southern Ave., Ste C108 - Mesa AZ 85206**
480-834-0771 PH 480-834-1136 FX

☐ **19841 N. 27th Ave., Ste 102 - Phoenix, Arizona 85027**
602-279-9848 PH 623-434-8310 FX

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name_____ **Date of Birth**_____

Address_____

City_____ **State**_____ **Zip Code**_____

SS Number_____ **Contact Number**_____

CENTRAL ARIZONA MEDICAL ASSOCIATES IS AUTHORIZED TO RELEASE INFORMATION TO:

☐ Name_____
Address_____
City_____ State_____ Zip Code_____
Phone_____ Fax_____

CENTRAL ARIZONA MEDICAL ASSOCIATES IS AUTHORIZED TO RECEIVE INFORMATION FROM:

☐ Name_____
Address_____
City_____ State_____ Zip Code_____
Phone_____ Fax_____

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care (excluding psychotherapy notes), alcohol and/or drug abuse treatment, and genetic testing, if any such records exist. I understand that Central Arizona Medical Associates will not condition treatment whether I sign this authorization. I understand that I have the right to revoke this authorization at any time except that the revocation will not apply to information that has already been released in response to this authorization. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address above. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal privacy regulations. I understand I may request a copy of this authorization.

I understand that this authorization will expire one (1) year from the date of signing unless specified here: Desired Expiration Date_____

INFORMATION TO BE RELEASED:

☐ Entire Medical Record
☐ Past _____Years
☐ Other *(please specify):*_____

PURPOSE/USE OF THE INFORMATION IS FOR:

☐ Personal Use
☐ Doctor
☐ Other *(please specify):*_____

_____ _____

SIGNATURE OF PATIENT/PARENT/*AUTHORIZED LEGAL REPRESENTATIVE **DATE**

_____ _____

PRINTED NAME OF PARENT/AUTHORIZED REPRESENTATIVE **RELATIONSHIP TO PATIENT**

Please provide legal documentation if signing on behalf of patient as a legal representative