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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I hereby authorize the disclosure of information from the health record of:

Patient's Name: ___________________________________ Date of Birth: ______________________

Former or Maiden Name: ____________________________ Phone Number: ______________________

Health Information to disclose:

□ Treatment Summary
□ Diagnoses
□ Labs and Imaging Results
□ Dates of Treatment Attendance
□ Progress Notes
□ Other (specify)_______________

Method of Disclosure:

□ Release Medical Records FROM East Valley Joint Clinic To:

Name: ____

Address: ____

Fax No.: ____

□Release Medical Records TO East Valley Joint Clinic From:

Name: ____

Address: ____

Fax No.: ____

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the request or on the following requested date:_________________.

____ __________________________________

Signature of Patient or Parent/Guardian/Executor Date

____

Relationship to patient