

Authorization to Release PHI

PHOENIX MEDICAL GROUP P.C.
9171 WEST THUNDERBIRD ROAD
PEORIA, AZ 85381

PHONE (623) 815-7800
FAX (623) 815-7900

I hereby authorize :

- | | | |
|--|---|---|
| <input type="checkbox"/> Dr. Orr | <input type="checkbox"/> Dr. Yonan | <input type="checkbox"/> Dr. Mojaverian |
| <input type="checkbox"/> Dr. Migotto | <input type="checkbox"/> Dr. Pierrend | <input type="checkbox"/> Christin Anzini P.A. |
| <input type="checkbox"/> Dr. Castro | <input type="checkbox"/> Ann Thogerson N.P. | <input type="checkbox"/> Dr. Madantschi |
| <input type="checkbox"/> Dr. Baldonado | <input type="checkbox"/> Kristi Hunter N.P. | <input type="checkbox"/> Dr. Arpino |
| <input type="checkbox"/> Dr. Tapia | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

to release medical records of:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

_____ DOS: _____

TO: _____

I would like my records sent in the following format: Electronically (Adobe PDF) Mail Fax

Please release the following information:

- | | |
|---|---|
| <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> Diagnostic Imaging |
| <input type="checkbox"/> Consults | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> EKG's | <input type="checkbox"/> All |
| <input type="checkbox"/> Other _____ | |

_____ If the patient has initialed on this line, this is a valid authorization for records including, but not limited to: psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501), drug abuse, alcoholism, or other substance abuse, sickle cell anemia, and records which may indicate the presence of a communicable or venereal disease which may include but are not limited to diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS testing or results.

Patient Signature

Date

Witness Signature (office use only)

Date

FILL OUT THE FORM COMPLETELY
Failure to do so **will** result in a delay of your release