*Records Released to Us

Patient Name: _____

Patient DOB: _____

Information to be release from (please provide name of doctor and name of clinic if possible):

Please provide the address, phone number, and fax number of the clinic (if known):

Information to be released to:
Desert Foothills Concierge Medicine
27805 N 154th St
Scottsdale, AZ 85262
P: 480.980.2735
F: 866.452.4194

Information to be Released:

☐ The most recent Visit Summary. ☐ Most recent lab records only. ☐ Other specific information (please specify below).

Other specific information to be released: _____

Purpose for which disclosure is being made:

☐ Doctor ☐ Attorney ☐ Insurance
☐ Personal

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drugs and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. *Exclude the following information from the records released:

☐ Substance abuse treatment/ diagnosis ☐ HIV/ AIDS diagnosis/ treatment/ testing ☐ Sexually Transmitted disease
☐ Psychiatric diagnosis/ treatment

MY RIGHTS:

I understand that authorizing this disclosure of patient health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I understand that unless expressly limited by me in writing, I am specifically authorizing the release of any sensitive medical information that may appear in my medical record including records mental health treatment including pain management, sexually transmitted diseases; AIDS/HIV treatment; and substance abuse. I understand once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. This authorization will expire 90 days from date signed below unless an extension is authorized.

PATIENT SIGNATURE _____

Printed Name of SIGNER (and relationship to patient if not signed by patient): _____

Date: _____