**Medical Information Release Form**

***Desert Foothills Concierge Medicine, LLC***

***28150 N Alma School Pkwy***

***Scottsdale, AZ 85262***

(HIPAA Release Form)

I, (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB:\_\_\_\_\_\_\_\_\_\_\_ hereby authorize (Releasing Organization)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and its affiliates, employees and agents, to release to **Desert Foothills Concierge Medicine, LLC** my personal health information including records detailing diagnosis, treatment, visit notes, imaging/lab results, claims payment and health care services provided or to be provided to me and which identifies my name, address, social security number and Member ID.

Any information NOT to be shared (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization is voluntary and that I may refuse to sign, however acknowledge that this may prevent my healthcare provider from accessing all necessary information to ensure that safe, effective and appropriate care can be provided. I understand that I have the right to revoke this authorization at any time. I also understand that I have a right to have a copy of this authorization upon request. This authorization is valid from the date of my signature below and shall expire only when I submit a written request to Desert Foothills Concierge Medicine, LLC.

Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_