Authorization to Receive PHI

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

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

I hereby authorize :

□ Dr. Orr	□ Dr. Yonan	□ Dr. Mojaverian
□ Dr. Migotto	□ Dr. Pierrend	□ Christin Anzini P.A.
□ Dr. Castro	□ Ann Thogerson N.P.	□ Dr. Madantschi
□ Dr. Baldonado	□ Kristi Hunter N.P.	□ Dr. Arpino
□ Dr. Tapia	□ _____	□ _____

to receive medical records of:

Patient Name: _____ DOB: _____

Address:_____ Phone: _____

_____ DOS: _____

FROM: _____

_____

_____

Please fax all medical records to expedite this request.

Please release the following information:

□ Laboratory Tests	□ Diagnostic Imaging
□ Consults	□ Office Notes
□ EKG's	□ All
□ 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