PHOENIX MEDICAL GROUP, P.C.

Authorization to Disclose PHI

9145 W THUNDERBIRD RD, #101
PEORIA, AZ 85381
P: (623) 815-7800
F: (623) 815-7900

I hereby authorize:

☐ Misbah Altaf, M.D	☐ Elena Ivanova, FNP	☐ Deborah Mescher, PA-C	☐ Lavanya Varma, M.D
☐ Srividya Ariyan, M.D.	☐ Michael Lepire M.D.	☐ Walter Migotto, M.D.	☐ Julie Wendt, M.D.
☐ G. Jerry Arpino, D.O.	☐ Theresa Macdissi, PA-C	☐ Ali Mojaverian, M.D	☐ Abdullah Yonan, M.D.
☐ Edward Au, D.P.M.	☐ Mohammad Madantschi, M.D	☐ Robert Orr, D.O.	☐ Jessica Zeman, M.D.
☐ Reginald Baldonado, M.D.	☐ Mahmoud Mahafzah, M.D.	☐ Jose Pierrend, M.D.	
☐ Heike Hilker, NP	☐ Gregory McClurg, NP	☐ Jordan Sennett M.D.	☐ _____

☐ *to RELEASE medical records of:* ☐ *to RECEIVE medical records of:*

Patient Name: _____ DOB: _____

Phone: _____

TO: _____

_____

_____

I would like my records sent in the following format: □ Mail □ Fax

☐ Office Notes	☐ Diagnostic Imaging	☐ Laboratory Tests
☐ 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.

_____I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can revoke this authorization, I can read the Phoenix Medical Group- Notice of Privacy Practices. To revoke my authorization, I must submit a written request to Phoenix Medical Group.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient Signature or Signature of Legal Representative (relationship) Date