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.	☐ Michael Lepire, M.D.	☐ Walter Migotto, M.D.	☐ Jordan Sennett, M.D.
☐ Srividya Ariyan, M.D.	☐ Theresa Macdissi, PA-C	☐ Ali Mojaverian, M.D.	☐ Lavanya Varma, M.D.
☐ Girolamo Arpino, D.O.	☐ Mohammad Madantschi, M.D.	☐ Robert Orr, D.O.	☐ Abdullah Yonan, M.D.
☐ Edward Au, D.P.M.	☐ Mahmoud Mahafzah, M.D.	☐ Jose Pierrend, M.D.	☐ Gregory Cowan, M.D.
☐ Heike Hilker, N.P.	☐ Deborah Mescher, PA-C	☐ _____	

Option 1

☐ *to **COPY** records belonging to:*

Option 2

☐ *to **RECEIVE** records belonging to:*

Patient's Name: _____ DOB: _____

Phone: _____

☐ ***release to:*** _____ ☐ ***receive from:*** _____

Address: _____

_____

Phone: _____ Fax: _____

I would like my records sent via ☐ MAIL ☐ FAX

☐ 3 recent office visits	☐ Recent Radiology	☐ Recent Labs	☐ Recent EKG
☐ Date Range _____ - _____		☐ Other _____	

I understand the issues discussed in this form. I release the provider, employees, officers and directors, medical personnel and business partners from any legal responsibility for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient Signature Date

_____ _____

Witness Name (for office use only) Date