

I hereby authorize:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Srividya Ariyan, M.D. | <input type="checkbox"/> Dustin Hahn, N.P. | <input type="checkbox"/> Debra Mescher, P.A-C | <input type="checkbox"/> Katarzyna Smith, P.A. | <input type="checkbox"/> Leonid Vydro, M.D. |
| <input type="checkbox"/> G. Jerry Arpino, D.O. | <input type="checkbox"/> Christy Hogue, N.P. | <input type="checkbox"/> Robert Orr, D.O. | <input type="checkbox"/> Shannon Steiner, N.P. | |
| <input type="checkbox"/> Melissa Chrisman, D.P.M. | <input type="checkbox"/> Misty Hull, N.P. | <input type="checkbox"/> Jose Pierrend, M.D. | <input type="checkbox"/> Abdullah Yonan, M.D. | |
| <input type="checkbox"/> Other: _____ | | | | |

To RELEASE medical records to: to RECEIVE medical records from:

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

For

Patient Name: _____ DOB: _____

Phone: _____

Purpose of Request: Personal Treatment Legal Insurance Transfer/Reason Other

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Diagnostic Imaging | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> EKG's | <input type="checkbox"/> Date from _____ to _____ | <input type="checkbox"/> Other _____ |

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

_____ 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.

This authorization will expire 90 days from the date appearing above. I 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 that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.

I understand Phoenix Medical Group will not condition treatment, payment, health plan enrollment, or eligibility of benefits on whether or not I sign the authorization and that I may refuse to sign.

I understand that I may inspect or copy the information that is used or disclosed.

Patient Signature or Signature of Legal Representative (relationship)

Date