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:

☐ Robert Orr, D.O
☐ Shannon Steiner, DNP
☐ Abdullah Yonan, M.D.
☐ Melissa Lockett, NP-C.
☐ Melissa Ries, D.P.M

☐ Other: _____

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

Patient Name: _____ DOB: _____

Phone: _____

*TO: Name/Facility:*_____ _____

Address:_____

Phone: _____Fax: _____

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

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

☐ Office Notes ☐ Diagnostic Imaging ☐ Laboratory Tests

☐ EKG's ☐ Date from_____ to_____ ☐ 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.

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