Caring for Families

# Authorization to OBTAIN Medical Information

**Patient Name:**_____**Birth Date:**____/____/___

**Address:**_____ **Apt #:**_____

**City:**_____ **State:**_____**Zip:**_____

**Phone:** (  ) _____

**Reason for Obtaining Medical Information:**

- □ Change in Primary Care Provider
- □ For other medical office review
- □ Other:_____

**Records Requested:**

- □ All (entire medical file)
- □ Other:_____

I authorize the RELEASE of records, including those which may contain CONFIDENTIAL HIV/AIDS RELATED INFORMATION, CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION, information relating to MENTAL HEALTH AND/OR ALCOHOL/DRUG USE, and CONFIDENTIAL GENETIC TESTING.

**I hereby AUTHORIZE;**

**Facility/Physician:** _____

**Address:** _____

**Phone:** (  ) _____ **Fax:** (  ) _____

to **RELEASE** all of the above requested information relative to my treatment and care to:

***Caring for Families, P.C.***
***13838 South 46th Place, Suite 125***
***Phoenix, Arizona 85044-6090***
***Phone (480) 783-7000 Fax (480) 783-9071***

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six (6) months from the date on which it is signed. Any disclosure of medical record information be the recipients is not authorized except when implicit in the purposes of the disclosure.

_____ _____/_____/_____

**Signature of Patient** **Date**

_____ _____

**Signature of other AUTHORIZED person** **Relationship to patient**

**If patient is a minor and information is to be released regarding treatment for alcohol/drug abuse, both the patient and parent/legal guardian must sign*