Caring for Families

Authorization to **RELEASE** Medical Information

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

Patient Name:_____ **Birth date:**_____/_____/_____

Address:_____ **Apartment #**_____

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

Phone: ( ) _____

Reason for Release of Medical Information:

- □ Attorney Review
- □ Employer
- □ No longer / Will no longer be a patient of Caring for Families
- □ Other Medical Office Review
- □ Personal Use / File
- □ Other:_____

Records to be Released:

- □ All
- □ 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, from Caring for Families, P.C.

I hereby **AUTHORIZE** Caring for Families, P.C**. to release** all of the above requested information relative to my treatment and care to:

Company/Person /Facility: _____

Address: _____

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

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 by 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 drug / alcohol abuse, both the patient and parent / legal guardian MUST sign