Caring for Families P.C.

13838 South 46th Place, Suite 125 Phoenix, Arizona 85044
Phone: (480) 783-7000 Fax: (480) 783-9071

Authorization to **RELEASE/OBTAIN** Medical Information

Patient Name: _____ Birth date: ____/____/____

Address: _____ Apt #_____ City: _____ State: _____ Zip Code: _____

Phone: ( ) _____

☐ I hereby **AUTHORIZE** Caring For Families P.C. **TO OBTAIN** all of the requested information listed below that is relative to my treatment and care from the facility listed below. ***PLEASE SUBMIT IN PAPER FORM NO CDs OR FLASH DRIVES***

☐ I hereby **AUTHORIZE** Caring for Families, P.C**. TO RELEASE** all of the above requested information relative to my treatment and care to the facility listed below: **We Do Not use CD or Flash drive format for Medical Records**

Reason for Release/Obtaining of Medical Information:

- ☐ **Attorney Review**
- ☐ **Employer**
- ☐ **Other Medical Office Review**
- ☐ **Change in Primary Care Provider**
- ☐ **Personal Use / File**
- ☐ **Other**_____

Records to be Released/Obtained:

- ☐ **All**
- ☐ **Labs**_____
- ☐ **Radiology** _____
- ☐ **Other (Please indicate specific records for us to release or obtain):**

_____

_____

***Please note we are unable to release other provider/facility records that have been sent to us, we are only able to release OUR records.**

I authorize the release/obtaining 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, to/from Caring for Families, P.C.

Facility/Company: _____ Provider Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

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