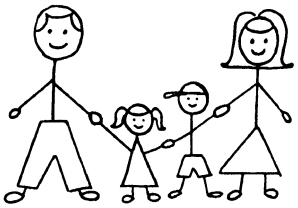

Accredited Family Healthcare

Cynthia Barry, D.O. • Katie Packer, N.P. • Candace Malson, N.P.
• Lea Stein, F.N.P • Shanna Hunt, F.N.P.

AUTHORIZATION FOR RELEASE OF INFORMATION

Re: _____ _____
Patient's Name (Print) Date of Birth

_____
Address (Street, City, State and Zip)

_____ Release records TO Accredited Family Healthcare from:
_____ Release records FROM Accredited Family Healthcare to:
Purpose of release _____

_____
Doctor or Medical Center

_____
Address

_____
FAX number

_____
PHONE number

AREAS OF SPECIFIC INTEREST OR CONCERN

All records _____ Illness/Hospitalization _____
Immunizations _____ Lab studies/Consultations _____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse, and genetic testing.

Disclosure: I understand that any disclosure of information carries with it the potential for disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already based on this authorization.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure medical treatment.

_____ _____
Signature of Patient or legal representative **Date**

725 West Elliot Road, Bldg. 3, Suite 105 • Gilbert, AZ 85233-5301 • Phone 480.963.6144 • Fax 480.899.1404