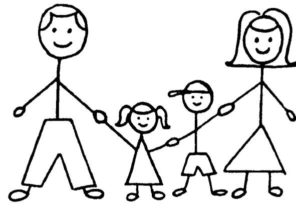

Accredited Family Healthcare

AUTHORIZATION FOR RELEASE OF INFORMATION

725 West Elliot Rd Bldg 3 Suite 105
Gilbert, Arizona 85233
Ph: (480)963-6144 Fax: (480) 899-1404

____ ______________________
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

____
PHONE number

____
FAX 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. This authorization expires 1 year from date of signature.

____ ______________________
Signature of Patient or Legal Representative **Date**