AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name:_____

Date of Birth:____/____/____ Social Security Number:_____/_____/_____

I hereby authorize use or disclosure of Protected Health Information (PHI) to be provided to or obtained by the following:

Facility/Company to Disclose PHI**:**_____		Facility to Receive PHI:	Price Family Medicine, PLLC
Address:_____		Address:	18301 N. 79th Ave., Ste C136
City, State:_____		City, State:	Glendale, Az. 85308
Phone:_____	Fax:_____	Phone :(623)776-2772	Fax No: (623)776-2666

Portions to Release are:
Complete Records **XX** (Other)_ _____ Dates of Service: (from)_____(to)**present**

The information obtained, used, or disclosed will be for the following purpose(s) only: Continuity of Treatment **XX**

I understand I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in the response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:_____

I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying, and mailing as authorized by law.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I have the right to inspect the health information to be released and I may refuse to sign this authorization.

Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV), or Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Description of Legal Representative's Authority Expiration Date of Authorization

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court of the Department of Health or by law.