



AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN# \_\_\_\_\_

I hereby authorize use or disclosure of protected health information about me.

I am authorizing the following location to release my records

From:

Dr/Facility \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

To:

Ocotillo Internal Medicine  
245 S. Dobson Rd.  
Chandler, AZ 85224  
480-895-5870 480-895-0573 Fax

Reason for release: \_\_\_\_\_

I understand that the information used or disclosed may be subject to re-disclosure by the person receiving it and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notification in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the provider to whom this authorization is furnished may not condition its treatment or me on whether or not I sign the authorization.

This authorization expires two (2) years from the date of execution.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date