EAST VALLEY FAMILY PHYSICIANS

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I HEREBY AUTHORIZE USE OR DISCLOSE MEDICAL RECORDS OF THE NAMED INDIVIDUAL AS DESCRIBED BELOW:

Name:_______________________________________**Dob:**______________**SS#**_______________

Address (street, city, state & zip)____

Treatment dates:______________________**Purpose or Request:**__________________________

The following information is to be disclosed: (Please check what is to be sent)

- ☐ COMPLETE MEDICAL RECORDS
- ☐ Physician Notes
- ☐ Lab Results
- ☐ X-Ray reports/Special studies
- ☐ Hospital
- ☐ Other____

(records form EVFP complete this side)

EAST VALLEY FAMILY PHYSICIANS
1455 W. Chandler Blvd, A-4
Phone 480-899-2900/Fax 480-899-0681
ATTN: Dr._____________________________

Is authorized to disclosure my records to:

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(records being sent to EVFP complete this side)

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Is authorized to disclosure my records to:

EAST VALLEY FAMILY PHYSICIANS
1455 W. Chandler Blvd, A-4
Phone 480-899-2900/Fax 480-899-0681
ATTN: Dr._____________________________

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.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and 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.

Expiration: Unless otherwise revoked, this authorization will expire on the date given below.
(If I do not specify an expiration date, this authorization will expire in six months.)

SIGNATURE of patient or legal representative______________________________**Date**_________

If legal representative, relationship to patient_________________**Expiration Date**___________