

CAMELBACK FAMILY HEALTH CARE

Anne-Marie Reed, D.O.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I request the medical records in its entirety to be released to the party(ies) designated below. This is an authorization with my full understanding that any and all information contained within my medical record is confidential and may contain sensitive data. I further understand that I have received and reviewed the patient privacy act in force at Camelback Family Health Care. I voluntarily authorize this request and understand all implications regarding this request.

Patient Name (Please Print Legibly) Date of Birth (MM/DD/YYYY) Social Security Number

Please Check One:

- Please Release My Complete Records
- Please Release The Following Dates of Service _____ to _____

Please release the health information **To / From (Circle One)**:

Name/Organization/Doctor:

Address: Street City State Zip

Phone: _____ Fax: _____

If you decide that you no longer wish to authorize the release of health information, you must fill out a written request stating as such.

Signature of Patient or Legal Representative Date

Print Name of Patient or Legal Representative Relationship to Patient (attach supporting document if not patient)