CAMELBACK HEALTHCARE™
COMPLETE CARE FOR YOUR WELL-BEING

Request For and Authorization To Release Medical Records Or Health Information
Must Complete To Process Request; Incomplete Request Will Be Denied

I authorize disclosure of my protected health information (PHI) as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other sensitive information. I understand that this authorization is voluntary, and that I may refuse to sign this authorization. I also understand that I may revoke this authorization at a later date by writing to the organization in question that possesses my PHI.

_____ _____ _____

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

☐ Please Release **My Complete Records**

☐ Please Release The Following Dates of Service _____ to _____

If necessary, please specify the contents to be released: _____

Reason for Records Release: ☐ Continuity of Care ☐ Specialist ☐ Establish New Primary Care Physician

☐ Legal ☐ Non-health Insurance Matter ☐ Other_____

☐ The PHI described be released **TO**: Camelback Health Care: Anne-Marie Reed DO PLLC, D.B.A.

3900 E Camelback Rd Suite 150, Phoenix, AZ 85018 –or- Fax Records to (602)680-7483

☐ The PHI described herein shall be released **FROM/TO** (Please Circle One):

_____

Name Address City State Zip

Phone Number: _____ Fax Number:_____

- I understand that this authorization will expire in ***180 days from the date of this authorization*** unless I specify in writing an alternate date or description of an event.
- I further understand that I may revoke this authorization at any time by notifying **Camelback Health Care - Anne-Marie Reed DO PLLC, D.B.A** hereby known as "Entity" at its lawful please of business. I also understand that the revocation of the request date must be signed, and the date must be later than the date on this authorization. Any actions taken by the Entity before receipt of the revocation of the request is not the responsibility of the Entity.
- I understand that if the recipient authorized to receive the information is not an Entity protected by the federal and state privacy regulations, the information released will not be protected by the applicable federal and state regulations.

_____ _____ _____

Patient Name Print or Patient Representative | Patient or Patient Representative Signature | Date

_____ *or* _____

Relationship to Patient | Legal Authority (Attach Supporting Documentation)