



4901 North 44th Street Phoenix Arizona 85018 www.camelbackhealth.com (602)368-5861 (P) (602) 680-7483 (F)

**REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL
RECORDS OR HEALTH INFORMATION | MUST BE COMPLETE
TO PROCESS REQUEST, INCOMPLETE REQUEST IS 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 I may refuse to sign this authorization. I also understand that I may also revoke this authorization at a later date by writing to the organization in question that possesses my PHI.

Print Patient Name
Please Print Clearly

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 _____

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

Reason for Records Release: ☐ Continuity of Care ☐ Specialist Referral ☐ Establish New Primary Physician Care
☐ Legal ☐ Non-health Insurance Matters ☐ Continuity of Care ☐ Other (Please Specify Below):

☐ The health information should be released **TO:**

**Camelback Family Health Care | D.B.A. ANNE-MARIE REED DO PLLC, 4901 North 44th Street Suite 102,
Phoenix, Arizona 85018 –or- Fax Records to Our Fax Server: (602) 680-7483**

☐ The health information described herein shall be released **from:**

Name	Address	City	State	Zip
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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 Family Health Care | ANNE-MARIE REED, D.O., P.L.L.C.** hereby known as "entity" at its lawful place of business. I also understand that revocation 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 revocation request is not the responsibility of the entity.

I understand that if the recipient authorized to receive the information is not a entity protected by federal and state privacy regulations, the information released will not be protected by applicable federal and state privacy regulations.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

or

Legal Authority (attach Supporting Documentation)