Authorization to Use or Disclose Protected Information

Patient Name: ____ Date of Birth: ____________________

I hereby authorize: (Name & Address) ***who is sending records***

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To disclose protected health information relative to my treatment and care to: (Name & Address) ***who is receiving records***

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Please release the following health care information (check all that apply):

___ Office Visits/Consultations ___ All Prenatal Records ___HIV/AIDS Records ___STD Records

___ Operative Reports ___ Laboratory Results ___ X-Ray/Ultrasounds

Reason(s) for this authorization (check all that apply):

___ At My Request ___ Further Medical Care ___ Insurance

___ Disability Determination ___ Attorney/Legal Investigation

I understand that I may revoke this authorization at any time with written request, except to the extent that action based on this authorization has already been taken. I may receive Palm Valley Women's Care Notice of Privacy Practices for more details. This consent will expire automatically 90 days from the date on which it is signed. All requests take 7-10 days to be completed and a $20 fee applies to records being released directly to the patient.

I understand the matters discussed on this form. I release the providers, its employees, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

____ __________________________

Patient or legally authorized individual signature Date

____ ____________________________________

Printed name if signed on behalf of the patient Authorized Representative & Relationship

13555 W. McDowell Rd., Suite 205 / Goodyear, AZ 85395 / ph 623-535-0740 / f 623-535-0741
10815 W. McDowell Rd., Suite 301 / Avondale, AZ 85392 / ph 623-433-0106 / f 623-433-0108
4920 W. Baseline Rd., Suite C103 / Laveen, AZ 85339 / ph 602-237-0808 / f 602-237-3611