AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: LENZMEIER FAMILY MEDICINE

PATIENT'S FULL NAME:

_____

ADDRESS: _____ PHONE: _____

_____

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

OBTAIN INFORMATION FROM: NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

Purpose of Disclosure: _____

RELEASE INFORMATION TO: **LENZMEIER FAMILY MEDICINE**

20100 N. 51st AVENUE, SUITE F630

GLENDALE, AZ 85308

Phone: (623) 376-8000 Fax: (623) 376-8040

_____

INFORMATION TO BE RELEASED:

_____COMPLETE MEDICAL RECORDS: *INCLUDING, BUT NOT LIMITED TO, AIDS/HIV AND OTHER COMMUNICABLE DISEASE INFORMATION, BEHAVIORAL HEALTH/PSYCHIATRIC CARE, ALCOHOL AND/OR DRUG ABUSE TREATMENT. Unless specified specifically:*

_____

_____OTHER (Specify):

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME AND THAT UPON FULFILLMENT OF THE ABOVE STATED PURPOSE(S), THIS CONSENT WILL AUTOMATICALLY EXPIRE 6 MONTHS FOLLOWING THE DATE OF SIGNATURE.

Signature of Patient/Guardian: _____ Date Signed: _____

Signature of Witness: _____Relationship to patient, if signed by Guardian: _____