AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FROM: LENZMEIER FAMILY MEDICINE

| PATIENT'S FULL NAME: | | |
|--|--|--|
| ADDRESS: | PHONE: SOCIAL SECURITY #: | |
| DATE OF BIRTH: | | |
| OBTAIN INFORMATION FROM: | LENZMEIER FAMILY MEDICIN | E |
| | 20100 N. 51 st AVENUE, SUITE F630 | |
| | GLENDALE, AZ 85308 | |
| | Phone: (623) 376-8000 | Fax: (623) 376-8040 |
| Purpose of Disclosure: | | |
| RELEASE INFORMATION TO: | | |
| | NAME: | |
| | ADDRESS: | |
| | PHONE: | FAX: |
| INFORMATION TO BE RELEASED:COMPLETE MEDICAL RECORI | DS: INCLUDING, BUT NOT LIMITED TO, | AIDS/HIV AND OTHER COMMUNICABLE DISEASE INFORMATION, |
| BEHAVIORAL HEALTH/PSYCHIATRIC CAI | RE, ALCOHOL AND/OR DRUG ABUSE TR | EATMENT. Unless specified specifically: |
| OTHER (Specify): | | |
| | | O THAT UPON FULFILLMENT OF THE ABOVE STATED S FOLLOWING THE DATE OF SIGNATURE. |
| Signature of Patient/Guardian: | | Date Signed: |
| Signature of Witness | Relationship to | nationt if signed by Guardian: |