Authorization for Release of Medical Records

Patient Name: ____
Date of Birth: _____________________________ Phone :_________________

The individual named above is authorizing the release of their Health Information from:

Physician or Practice Name:
____

Address:
____
City: _____________________________ State: _______ Zip: ______________Phone:______________

This information may be released to and used by

PEBBLE CREEK MEDICAL GROUP PLLC
700 N ESTRELLA PKWY, # 130 GOODYEAR, AZ 85338
Office # 623-322-2144 Fax # 623-322-1165

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

______ Complete health records ______ Lab results/X-ray reports
_____ Pathology Reports _____ Consultation reports
______ Mammography Reports
_____ Other (please specify):____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient Signature____ Date______________________

PLEASE NOTE:

This information has been disclosed from confidential records protected from disclosure by state and federal law. No further disclosure of this
information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and
federal law 42 CFR, part II.