Internal Medicine of Arizona
3333 E Camelback Road Ste 122
Phoenix, Arizona 85018
PH: 602-522-1900 | Fax: 602-381-3281

I, ___________________________________ authorize the release of my records from other medical facility:

Facility/ Dr Name: ____

Phone ____________________________________ Fax: ____

to the Physician/ PA listed below**:**
Wayne Kuhl, MD ___ , Jeff Nebelsieck, MD___, Tamara Lieberman, MD___, Greg Johns, MD___,
Laura O'Malley, MD___, Rebecca Rowen, PA-C___

2. Effective Period This authorization for release of information covers the period of healthcare from:
____/_____/_____ to _____/_____/_____ **OR** □ all past, present, and future periods.

3. Extent of Authorization
a. □ I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.
OR
b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): ____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, orother purposes as I may direct.

5. This authorization shall be in force and effect until ______/______/_______ at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature: ____ Date: ____/____/____

Printed name: ____ DOB: ____/____/____

IF MORE THAN 20 PAGES- PLEASE DO NOT FAX