



**INTERNAL MEDICINE OF ARIZONA**  
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**HIPAA MEDICAL INFORMATION RELEASE FORM**

**I AUTHORIZE INTERNAL MEDICINE OF ARIZONA TO RELEASE AND DISCUSS MY  
MEDICAL HISTORY AND MEDICAL CONDITION WITH:**

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**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

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**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_