**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___, Alan Andresen, MD___, Rebecca Rowen, PA-C___ Cory Buschmann, MD ___**

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

**3. Extent of Authorization**
a. □ I authorize the release of my complete health record including recordsrelating to mental healthcare, communicable diseases, HIV or AIDS, and treatment ofalcohol 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 receivethis 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 anyperson or entity has already acted in reliance on my authorization or if myauthorization was obtained as a condition of obtaining insurance coverage and theinsurer has a legal right to contest a claim.

**Signature**:_____ Date: ____/____/____

Printed name: _____ DOB: ____/____/____

## ***IF MORE THAN 20 PAGES- PLEASE DO NOT FAX***