AUTHORIZATION TO RELEASE MEDICAL RECORDS

Joshua Medical Group

Patient's name: _____ Date of Birth: _____

I request and authorize:

Name: _____

Address: _____

Phone: _____ Fax: _____

To release healthcare information regarding the above named patient to: **Joshua Medical Group Email – receptionist@joshuamedicalgroup.com**

Specific description of the information that may be disclosed:

_____

Description of what the purpose of this disclosure is:

_____

Validity of Authorization Form:

This authorization is valid for **Ninety (90)** days from to signed date below.

Acknowledgement:

I/We understand I have the right to revoke this authorization (in writing) at any time, except to the extent that action has been taken in reliance of this authorization. Joshua Medical Group requires a 1 week processing time, records may not be available until after this time period.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above (Re-disclosure Law A.R.S. Section 36-662 G).

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above (Confidential Law A.R.S. Section 36-506 and Re-Disclosure Law C.R.F. Part II).

Patient Signature: _____ Date: _____

Parent/Legally Authorized: _____ Relationship: _____ Date: _____

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