MOUNTAIN VIEW FAMILY PHYSICIANS
MEGGAN BAUER M.D., MICHAEL J. BRENNAN M.D., ROSEANNE K. COLLINS M.D., ANDREW C. DAVEY M.D., MAYY DEADRICK M.D., VERONICA LINDO M.D., SHAYNA MANSFIELD D.O., JENNIFER SMITH D.O.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(THIS FORM MUST BE FILLED OUT COMPLETELY BEFORE RECORDS CAN BE RELEASED)

I hereby authorize **the party listed below** to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Print Patient Name _____ Date of Birth _____ Social Security Number _____

Date(s) of service (if known): _____

Description of information to be released:

All my health information as described above, unless specifically excepted: _____

The reason or purpose of the use and/or disclosure: ❒ Continuing medical care, or _____

_____

The health information described herein shall be released ***to***:

Mountain View Family Physicians,

❑ Dr. Bauer ❑ Dr. Brennan ❑ Dr. Collins ❑ Dr. Davey
❑ Dr. Deadrick ❑ Dr. Lindo ❑ Dr. Mansfield ❑ Dr. Smith

By mail to: 4250 E. Camelback Road, Suite K100, Phoenix, AZ 85018

Or by fax to: (602) 224-0078

The health information described herein shall be released ***from***:

Name Address City State Zip

I understand that this authorization will expire by law ***180 days from the date of this authorization*** unless I otherwise specify by date or by an event. I desire this authorization to be in effect until _____
expiration event/date

I further understand that I may revoke this authorization at any time by notifying **Mountain View Family Physicians** in writing at **4250 E. Camelback Rd., K100, Phoenix, AZ 85018.** 1 also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that if the recipient authorized to receive the information is not a covered entity — e.g. health insurance plan or health care provider — the released information may no longer be protected by federal and state privacy regulations.

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient's Representative _____

Relationship to Patient _____ *or* Legal Authority (attach Supporting Documentation) _____