**AUTHORITY TO USE OR DISCLOSE HEALTH INFORMATION**

Patient Name:
Date of Birth:
Social Security Number:

PLEASE RELEASE THE FOLLOWING INFORMATION:

| | | | |
|---|---|---|---|
| ☐ | problem list | ☐ | any and all lab results |
| ☐ | medication list | ☐ | any and all x-ray and imaging reports |
| ☐ | list of allergies | ☐ | consultation reports from any and all doctors |
| ☐ | immunization records | ☒ | entire record |
| ☐ | most recent history | ☐ | psychological records |
| ☐ | most recent discharge summary | ☐ | other _____ |

THE PURPOSE OF THIS REQUEST IS FOR:

| | | | |
|---|---|---|---|
| ☐ | The Disclosure is at my (patient's) request | ☐ | Government Agency/Police |
| ☐ | Further Medical Care | ☒ | Attorney/Legal Investigation |
| ☐ | Disability Determination | ☐ | Personal Use |
| ☐ | Insurance | | |

I HEREBY AUTHORIZE: _____
COMPANY, PERSON, FACILITY
_____ TO DISCLOSE PROTECTED
ADDRESS
HEALTH INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

Brian T. Allen
Udall, Shumway & Lyons, P.L.C.
30 W. First Street
Mesa, AZ 85201

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will automatically expire six months from the date signed below.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

_____ _____
Signature of witness Date

If patient is unable to consent by reason of age or some other fact, state reasons: _____
_____

_____ _____ _____
Legally Authorized Representative Date Relationship to Patient

*If patient is a minor and information is to be released regarding treatment of alcohol or drug abuse, both the patient and parent or legal guardian must sign.