AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FROM: LENZMEIER FAMILY MEDICINE

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

OBTAIN INFORMATION FROM: **LENZMEIER FAMILY MEDICINE RECORDS**
20100 N. 51st AVENUE, SUITE F630
GLENDALE, AZ 85308

Purpose of Disclosure: _____

I authorize Lenzmeier Family Medicine to release or transfer my medical records to:

NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

EMAIL: _____

INFORMATION TO BE RELEASED:

____ COMPLETE MEDICAL RECORDS: INCLUDING, BUT NOT LIMITED TO, AIDS/HIV AND OTHER COMMUNICABLE DISEASE INFORMATION, BEHAVIORAL HEALTH/PSYCHIATRIC CARE, ALCOHOL AND/OR DRUG ABUSE TREATMENT. Unless specified specifically:

_____

____ OTHER (Specify): _____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME & THAT UPON FULFILLMENT OF THE ABOVE-STATED PURPOSE(S), THIS CONSENT WILL AUTOMATICALLY EXPIRE 12 MONTHS FOLLOWING THE DATE OF SIGNATURE.

Signature of Patient/Legal Representative: _____

Printed Name: _____ Date Signed: _____

Relationship to patient, if signed by Legal Representative/Guardian:

_____

_____

Please mail this completed form to Lenzmeier Family Medicine 20100 N 51st Avenue, Suite F630, Glendale, AZ 85308 along with a copy of a Government Issued Photo ID (required for identity verification)