

Sage Health Family Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Birthdate: _____

Medical Information to be Sent From:	Physician / person / company to receive records
Provider/Clinic: _____	Name <u>Sage Health Family Medicine Dr. Stanley Wen</u>
Address _____	Address <u>14419 W. McDowell Rd. Suite E102</u>
City _____	City: <u>Goodyear</u>
State _____ Zip _____	State: <u>AZ</u> Zip: <u>85395</u>
Phone(____) _____ Fax(____) _____	Phone: <u>(623)535-3857</u> Fax: <u>(623)535-4310</u>

_____ Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

_____ Entire Medical Record, *EXCLUDING* information related to the treatment for:
Substance abuse or dependency
Psychiatric or mental health treatment
Information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

_____ Record of care from _____ to _____ *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

_____ Record of care from _____ to _____ *EXCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV / AIDS.

I RECOGNIZE THAT UNDER the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I may limit the scope of the information that I authorize be disclosed. It is my expressed wish that **all medical records of whatever kind, as described above, be released, subject only to any limitations. If you have any limitations please list them here:**

_____ If deemed necessary by Doctor _____, I authorize this information to be sent via FAX transmission. HIV, AIDS, and Mental Health records may not be FAXED unless it is an emergency.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective for a period of one year unless otherwise stated _____. I may revoke my consent at any time by providing written consent to the above named party.

I FURTHER UNDERSTAND that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and thereafter no longer subject to protection under HIPAA.

Signature of Patient or Patient's Legal Guardian

Date

Witness

Date