Internal Medicine of Arizona
Wayne Kuhl, M.D., Jeffrey Nebelsieck, M.D.
Gregory Johns, M.D., Laura O'Malley, M.D.
Cory Buschmann, M.D., Alan Andresen, MD
Rebecca Rowen, P.A.-C, Diego Alvarado, PA-C
Glenda Weisman, M.D., Katherine Duncan, M.D.
Chi Duong, D.O., Ann Lacey, F.N.P.

I, _____ authorize the release of my records from **other medical facility:**

Facility/ Dr Name: _____

Phone _____ Fax: _____

to the Physician/ PA listed below:
Chi Duong, D.O. ___ , Jeff Nebelsieck, MD___, Greg Johns, MD___, Laura O'Malley, MD___, Ann Lacey, F.N.P. ___
Alan Andresen, MD___, Rebecca Rowen, PA-C___ , Cory Buschmann, MD ___, Glenda Weisman, MD ___, Diego Alvarado, PA-C

2. Effective Period This authorization for release of information covers the period of healthcare from: ____/_____/_____ to _____/_____/_____**OR** □ all past, present, and future periods.

3. Extent of Authorization
a. □ I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.
OR
b. □ I authorize the release of my complete health record except for the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____/_____/_____ at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature:_____ Date: ____/____/____

Printed name: _____ DOB: ____/____/____

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