Christina Kwasnica, MD
Matthias Linke, DO
David Jung, MD
Joseph Ostler, MD, PhD

VPMR
#ENHANCINGYOURQUALITYOFLIFE
WWW.VPMR.NET

Authorization To Use or Disclose Protected Health Information

I authorize Valley Physical Medicine & Rehabilitation, PC to disclose protected health information (PHI) from my health record to the individual or facility listed below.

For Patient: _____

Date of Birth: _____/_____/_____ **SSN:** _____--_____--_____

Please release all medical records or requested information to the below named doctor or facility:
Name, Address and Phone Number of Recipient:

_____

_____

_____

_____

_____

Specific Information to be Disclosed:

_____

_____

_____

I authorize the provider to use or disclose information related to: (Circle Yes or No)

AIDS/HIV and other Communicable Diseases	☐ **Yes** ☐ **No**
Behavioral Health Care/Psychiatric Care	☐ **Yes** ☐ **No**
Alcohol and/or Drug Abuse Treatment	☐ **Yes** ☐ **No**

_____ 05/03/2021
Patient's Signature **Date**

_____ _____
Signature of Legal Representative **Relationship to Patient or Description of Authority to Act for Patient**

Release is valid for one-year beginning signed effective date. To revoke my authorization, I must submit a written request to Valley Physical Medicine & Rehabilitation, P.C.

222 W. Thomas Rd. Ste. 114
Phoenix, AZ. 85013
Phone 602-406-6304
Fax 602-406-6302
Suzanne Kelley, NP
Kenneth Vickroy, NP