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Authorization To Use or Disclose Protected Health Information

I authorize _____ 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:

Valley Physical Medicine & Rehabilitation, P.C.
Provider (if applicable):_____
222 W. Thomas Rd, Ste 114, Phoenix, AZ 85013
Fax: (602) 406-6302 Phone: (602) 406-6304

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.