MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Name: _____ **Date of Birth:** _____

I authorize you to **obtain** my records **FROM**:

Name: _____

Address: _____

City & State: _____

FAX : _____

I authorize you to **release** my records **TO**:

Name: Shafa Medical Clinic PC
Amanda Modesta-Keyhani MD FACP

Address: 202 East Earll Drive Suite 150

City & State: Phoenix , Arizona 85012

FAX : 602-248-8259 Phone: 602-248-8258

This authorization ends: on (date):_____

Authorization : You may use or disclose the following health care information (check all that apply):
All my health information including, but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and/or drug abuse treatment, if any, unless specifically excepted
_____

My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

All psychotherapy notes, unless specifically excepted: _____

2. **My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study, or to receive health care when the purpose is to create health information for a third party. I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it. I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Printed Name (If Signed on Behalf of the Patient Date