

ADELANTE HEALTHCARE

Buckeye 306 E. Monroe Buckeye, AZ 85326 Ph: 877-809-5092 FAX: 623-386-4593	Gila Bend PO FF Gila Bend, AZ 85337 Ph: 877-809-5092 FAX: 623-932-5725	Mesa 2204 S. Dobson Rd Suite 101 Mesa, AZ 85202 Ph: 877-809-5092 FAX: 480-491-6239	Phoenix 7725 N. 43 rd Avenue Suite 510 Phoenix, AZ 85051 Ph: 877-809-5092 Fax: 602-843-1560	Surprise 16560 N. Dysart Rd. Surprise, AZ 85374 Ph: 877-809-5092 FAX: 623-546-3514	Wickenburg 811 N. Tegner Suite 113 Wickenburg, AZ 85358 Ph: 877-809-5092 FAX: 623-583-8330	Sun City – OB/GYN 14300 W. Granite Valley Suite A1 Sun City West, AZ 85375 Ph: 877-809-5092 Fax: 623-544-3368
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AUTHORIZATION TO RELEASE / DISCLOSE MEDICAL RECORDS

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Date(s) of Treatment: _____

Name and Address of Organization, Entity, or Person(s) Who Will Receive Records: _____

Purpose of Release: Medical Care _____ Legal _____ Insurance _____

Other (Please Specify): _____

I hereby authorize _____ to provide the above named organization, entity or person(s), with a copy of any and all information, records, documents, reports, psychiatric records, clinical abstracts, histories, and charts of every kind and description, relating to my treatment and care during the above described date(s) of treatment. **This release constitutes a general authorization to release medical information and records, including without any limitation confidential alcohol or drug usage or HIV related information and records.**

This consent may be revoked at any time except to the extent that any action has been taken in reliance on it. In the absence of an express written revocation, this consent expires _____ days from the date of signature.

In furtherance of this authorization, I am waiving all provisions of state and/or federal law and all state and federal privileges relating to the disclosures authorized.

 Patient Signature Date

 Parent Signature Date

If patient is unable to consent, state reason(s): _____

 Signature of Legally Authorized Representative Date

 Signature of Witness Date