Jennifer Fontius, MD

General Medical Records Release and Authorization for Use of Disclosure of Protected Health Information

Name of Patient: _____

Date of Birth: _____ **Date(s) of Service:** _____

I, the undersigned, authorize the release of, or request access to, the information specified below from the medical record of the above named patient.

Information to be Released:

_____ All records for past 12-24 months
_____ Labs/pathology
_____Imaging report
_____ Other: _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing disclosure of this information.

From: _____ _____
(Name of provider, clinic, hospital, etc.) Telephone number

_____ _____
_____ Fax number
(Address)

To: **Jennifer Fontius, MD** **Telephone: 480.563.3211**
7629 E Pinnacle Peak Road #108 **Fax: 480.999.3966**
Scottsdale, AZ 85255

I understand that I may revoke this authorization in writing at anytime except to the extent that action has been taken in reliance upon the authorization.

Signature: _____ **Date:** _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Representative