I, _____(patient name), _____(date of birth), hereby authorize the use or disclosure of medical records

TO SUPERSTITION VITALITY CENTER

FROM: _____
(PHYSICIAN/GROUP NAME) (PHONE) (FAX)

OR

TO_____
(PHYSICIAN/GROUP NAME) (PHONE) (FAX)

FROM SUPERSTITION VITALITY CENTER

FOR TRANSFER OF CARE / CONTINUITY OF CARE (CIRCLE ONE)

I authorize the following information to be disclosed:

_____ COMPLETE MEDICAL RECORD

_____ PROGRESS NOTES

_____ LABS/PATHOLOGY REPORTS

_____IMAGING REPORTS ONLY

OTHER_____

I UNDERSTAND THE INFORMATION IN MY RECORDS MAY CONTAIN INFORMATION RELATED TO HIV/AIDS, COMMUNICABLE DISEASES, MENTAL HEALTH, DRUG/ALCOHOL ABUSE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANYTIME. I UNDERSTAND THAT THIS IS VOLUNTARY AND I DO NOT NEED TO SIGN THIS FOR MEDICAL TREATMENT, A COPY OF THIS IS VALID AS ORIGINAL AND WILL EXPIRE 1 YEAR FROM THE DATE BELOW.

DATE: _____
PATIENT/RESPONSIBLE PARTY SIGNATURE_____

WITNESS INITIALS_____

Superstition Vitality Center, LLC
312 N. Alma School Rd. Ste#1 Chandler, AZ 85224
Office: 480-857-3187
Fax: 480-857-3467

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