

## Medical Records Release Authorization

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other names used by patient: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize the following physician:

Physician name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

To release COMPLETE health records to:

G & K MEDICAL ASSOCIATES, P.C.  
10450 W MCDOWELL ROAD, SUITE 101  
AVONDALE, AZ 85392  
PHONE #: 623-935-1000  
FAX #: 623-935-1022

I understand that specific information to be released may include AIDS or HIV, alcohol and/or drug abuse, and mental health. Unless otherwise indicated this authorization will never expire from the date signed or as specified: \_\_\_\_\_ the physician and the employees are release from any legal responsibility or liability for disclosure of the above information to the evoked in writing at any time, except to the extent that an action has been taken in reliance on this authorization for the purposes stated above.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient-Signature

\_\_\_\_\_  
Relationship to patient