FROM THE OFFICE OF:
Elizabeth A. McMorran, NP
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Phone: **480-632-5800**
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Authorization for the Release of Information

I _____ with DOB: ___/___/_____
authorize Elizabeth A McMorran NP to **release the information described below to:**

_____

_____

and to receive from this same office/agency/person/recipient:

Notice to Recipient: This information has been disclosed to you and/or from you through records that Federal law protects. These records are not subject to re-disclosure.

Information to be disclosed includes but is not limited to: (please check all that apply)

_____ Claims/Explanation of Benefit Information
_____ Diagnosis/Prognosis
_____ Progress Notes
_____ Other (Specify) _____
_____ Psychiatric Evaluation
_____ Medications
_____ Test Results/Labs

Purpose for Disclosure: _____

I understand that at any time I may revoke this authorization in writing. The revocation will be effective except to the extent that the action based on this authorization has already been taken. Authorization will expire one year from this date unless otherwise noted.

In accordance with A.R.S. 12-2292. Confidentiality of medical records and payment records:

A. Unless otherwise provided by law, all medical records and payment records, and the information contained in medical records and payment records, are privileged and confidential. A health care provider may only disclose that part of all of a patient's medical records and payment records as authorized by state or federal law or written authorization signed by the patient or the patient's health care decision maker.

B. This article does not limit the effect of any other federal or state law governing the confidentiality of medical records and payment records.

_____ _____
Signature of Individual/Guardian Date

_____ _____ _____
Relationship Witness Date