HealthFirst Primary Care
Shilpa Bhatnagar, M.D. Shobha Parvathala, M.D.
2153 E. Baseline Rd. Suite 101
Tempe, AZ 85283
Phone: 480-820-1855 Fax: 480-820-8451

AUTHORIZATON FOR RELEASE OF RECORDS

Patient's Name_____DOB_____SSN_____

Address_____
Street Apt. City State Zip

Telephone _____ Work/cell_____

I hereby authorize *HFPC* (check one) TO { } obtain from: or { } release to:

Facility/Physician_____

Address_____
Street Apt. City State Zip

Telephone_____ Fax _____

I hereby authorize the release of photocopies or faxes of the following medical records:
For the purpose hereof, "medical Records" shall include:
1. Confidential HIV related information (as defined in A.R.S. Section 36-6610).
2. Confidential communicable disease related information (as defined in A.R.S. Section 36-6610).
3. Confidential alcohol or drug abuse related information (as defined in 42 CEB Section2.1 E T SEQ).
4. Confidential mental health diagnosis and treatment information.
5. Confidential genetic testing information (as defined in A.R.S. Section 12-3801).

I hereby consent that the following information may be used or disclosed:

___ Medical Records, Last 2 years ___ List of allergies ___ Problem list
___ Medication List ___ Immunization Records ___ Lab Results
___ X-ray and Imaging Reports ___ EKG ___ Other_____

ALL medical records covering date(s): _____ to _____
The information for which I am authorizing disclosure will be used for the following purpose:
___ My personal records (Fee of $15 and up) ___Sharing with other healthcare provider

___ Other (Please Describe)
_____

- I hereby release your physicians and employees from any liability for fulfilling the authorization request for release of medical information
- This consent will expire sixty (60) days after signed date below. I have given consent voluntarily and without coercion
- I may revoke this authorization at any time by notifying HealthFirst Primary Care, P.L.L.C. in writing
- I understand that any release not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.
- I understand that a photocopy facsimile of this authorization is considered in lieu of the original.
- Treatment will not be conditioned on my proving this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I release HealthFirst Primary Care, Shilpa Bhatnagar, M.D., Shobha Parvathala, M.D. and staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____**Date**_____
Signature of patient

_____**Date**_____
Signature of parent/guardian, power of attorney/personal representative