## ***PATIENT AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION TO DIABEVITA***

Patient Last Name ______________________________ First Name ________________________ Middle __________

Date of Birth ____________________________ Gender: ____ Male ____ Female

**RELEASE HEALTH INFORMATION FROM: Physician Name** ______________________________________

Phone Number ____________________________ Fax Number ___________________________________________

Address ________________________________________ City ___________________ St ______ Zip _____________

The health care provider above should send the specified records to us at the address, fax or email below. If there are charges, please advise the patient. Please call us if additional information is needed. We appreciate your cooperation!

Helen Hilts, MD
7400 McDonald Drive, Suite 105
Scottsdale AZ 85250
(480) 315-9757. Fax: (480) 315-9758
admin@diabevita.com • www.diabevita.com

**SPECIFIC HEALTH INFORMATION TO BE RELEASED:**

__X__ Problem List
__X__ Visit Notes (Last 3 visits)
__X__ Laboratory Reports (Last 2 years)
__X__ Diagnostic Reports (ALL)
__X__ Consults
_____ Complete Record (Last 3 years)
____ Immunization Records (All)
____ Medication List
____ Specific records relating to _________________________________________________

**AUTHORIZATION AND RELEASE:**

By signing below, I hereby consent and authorize the above-named party to release my medical records, including current and past records as specified, to the DiabeVita Medical Center. I understand that this authorization includes consent for the release of information, unless limited above, relating to the patient's medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected by State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation of this authorization in writing to the releasing party. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

Signature of Patient or Legal Representative ________________________________________________

Relationship to Patient _______________________________ Date _________________________________

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# ***PATIENT AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION FROM DIABEVITA***

Patient Last Name ______________________________ First Name ________________________ Middle __________

Date of Birth ____________________________ Gender: _____ Male ____ Female

**HEALTH INFORMATION IS TO BE SENT TO: Physician Name** ______________________________________

Phone Number ____________________________ Fax Number ____________________________________________

Address _________________________________________ City ___________________ St ______ Zip _____________

**SPECIFIC HEALTH INFORMATION TO BE RELEASED:**
____ Problem List ____ Medication List ____ Complete Record (Last 3 years)
____ Laboratory Reports (Last 3 years) _____ Diagnostic Reports (Last 3 years) ____ Immunization Records (All)
____ Specific records relating to _______________________________________________________________________

**AUTHORIZATION AND RELEASE:**
By signing below, I hereby consent and authorize the release of the above-listed patient's medical records, including current and past records. I am either the patient or legal guardian, and if the latter, I have provided DiabeVita with an executed power-of-attorney by the patient. I understand that this authorization includes consent for the release of information, unless limited above, relating to the patient's medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected by State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation of this authorization in writing to DiabeVita. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the third party and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative_________________________________________________________________

Relationship to Patient ________________________________________________ Date ______________________________

**FOR OFFICE USE ONLY:**
Request Approved ______________________ Date Records Sent ________________________ Records sent via ___________

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# ***PATIENT AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION FROM DIABEVITA***

Patient Last Name ______________________________ First Name ________________________ Middle __________

Date of Birth ____________________________ Gender: _____ Male _____ Female

## HEALTH INFORMATION MAY BE RELEASED TO or DISCUSSED WITH:

**Name** ______________________________________________________ Relationship __________________________

Primary Phone Number ___________________________ Secondary Number___________________________________

Address _________________________________________ City ___________________ St _______ Zip _____________

## SPECIFIC HEALTH INFORMATION TO BE RELEASED:

____ All information pertaining to my health
____ Specific information (please specify) _________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

## AUTHORIZATION AND RELEASE:

By signing below, I hereby consent and authorize the release of the above-listed patient's medical records, including current and past records. I am either the patient or legal guardian, and if the latter, I have provided DiabeVita with an executed power-of-attorney by the patient. I understand that this authorization includes consent for the release of information, unless limited above, relating to the patient's medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected by State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation of this authorization in writing to DiabeVita. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. You may revoke this authorization, in writing at any time. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the third party and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative_________________________________________________________________

Relationship to Patient ________________________________________________ Date _______________________________