AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the Physician/ Organization stated below to release my medical records -

PHYSICIAN/ PRACTICE		Phone #	
	Address	Fax	
Date of Service	**From**_____	**To**_____	
INFORMATION	**X All Pertinent Medical Reports**	**X Lab Reports**	**X Other**
PURPOSE	**For Continuing Medical Care**		
	□ Other (specify reason)_____		
INFORMATION TO BE SENT TO	**Desert Rose Medical Consultants, P.C.**	**Veena Gulaya, MD/ Devendra Gulaya, MD**	
	10320 W McDowell Rd, N1445 Avondale, AZ 85392 Address Zip Code	**(623) 547-2100 (623) 547-3005** Phone Fax	

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

If I refuse to sign this authorization form. I understand that Desert Rose Medical Consultants, P.C. holds the right to not accept me into their practice.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, it will expire 6 months from the date signed or as specified:_____

I release the above noted agency, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

PATIENT INFORMATION	Patient Name	Date of Birth	
	Address	Phone #	

Signature of Patient	Date	If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign. (separate release form)
Signature of Legal Representative	Relationship to Patient **or** Description of Authority to Act for Patient	

DATE FAXED _____ **INITIALS**_____