PARKVIEW INTERNAL MEDICINE
14869 W. Bell Rd. Bldg. 4 Ste 101
Surprise, AZ 85374
P: (623)544-1700 F: (623)544-7544

Authorization for Release of Medical Records

Patient Name: _____
Date of Birth: _____ Phone :_____

The individual named above is authorizing the release of their Health Information from:

Physician or Practice Name:
_____

Address:
_____
City: _____ State: _____ Zip: _____Phone:_____

This information may be released to and used by

Parkview Internal Medicine
14869 W. Bell Rd. Suite 101
Surprise, AZ 85374
Office: 623-544-1700 Fax: 623-544-7544

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records _____ Lab results/X-ray reports
_____ Pathology Reports _____ Consultation reports
_____ Mammography Reports
_____ Other (please specify):_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient Signature_____ Date_____

PLEASE NOTE:

This information has been disclosed from confidential records protected from disclosure by state and federal law. No further disclosure of this
information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and
federal law 42 CFR, part II.