THE MAXWELL GROUP
14678 N DEL WEBB BLVD. SUN CITY, AZ 85351-2137
PHONE (623) 933-8289 FAX (623) 933-2596

AUTHORIZATION TO RELEASE RECORDS

Please fill out and send to your previous Primary Care Physician prior to your appointment

Patient Name _____ D.O.B._____

Social Security # _____ Phone _____

Address: _____
(City) (State) (Zip)

FROM DR: **SEND TO:**

NAME NAME

(Address) (Address)

(City, State, Zip) (City, State, Zip)

(Phone, Fax) (Phone, Fax)

Purpose of Release

☐ Specialist (we send) NO charge ☐ Leaving Practice(new PCP,we send) NO charge
☐ Personal/Attorney/Life Insurance (printed) $25 /plus .10per pg/postage ☐ CD $25 plus postage

Information to be Released **(2 years maximum unless requested)** **Method of Delivery**

☐ Office Notes ☐ Colonoscopy ☐ Paper
☐ Laboratory Tests ☐ Mammogram ☐ Disc
☐ Imaging Reports ☐ Dexa Scan ☐ Fax 623-933-2569

I understand this consent is voluntary and that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Revocation must be a written, dated and signed communication. Unless I revoke this authorization in writing, it will remain in effect with no expiration. I understand that my health record may include Behavioral Health Information, Drug/Alcohol information, Sexually Transmitted Disease information, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable disease information. My signature authorizes release of any such information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer protected by the federal HIPAA Privacy Rule.

I may refuse to sign this authorization form. I understand that The Maxwell Group will not condition or deny treatment on my signing this authorization. I understand that I have a right to receive a copy of this authorization.

_____ _____
Patient Signature Date