



INTERNAL MEDICINE

AZ

Geriatric Specialties of Arizona

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Authorization to Release Protected Health Information

Please use this form as a cover sheet.

I, _____ DOB _____ authorize Internal Medicine AZ (Geriatric Specialties of Arizona) to **obtain** my medical information from the provider or company listed below, for the purpose of researching in my medical history.

I, _____ DOB _____ authorize Internal Medicine AZ (Geriatric Specialties of Arizona) to **release** my medical information to the provider or company listed below and /or myself.

Dates of Service or Events to be released:

Physician Office/ Patient: _____

Address: _____

Phone: _____ Fax: _____

My signature authorizes such release as indicated above. I understand that I am under no obligation to sign this form and I have a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above to use or disclose my health information in the manner described above.

Signature of Patient/ POA: _____ Date: _____

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