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**AUTHORIZATION TO USE OR DISCLOSE  
 PROTECTED HEALTH INFORMATION**

**I authorize Gavilan Peak Family Practice to disclose the following information from the health record of:**

<b>PATIENT IDENTIFICATION</b>  <i>All information must be filled out completely to process your request</i>	Patient Name _____ Date of Birth _____
	Address _____ Phone Number _____
	City _____ State _____ Zip _____
	<b>Dates of Service:</b> From _____ To _____
<b>INFORMATION REQUESTED</b>	<input type="checkbox"/> Office Visit Note(s) <input type="checkbox"/> Pathology Report <input type="checkbox"/> <b>Specify:</b> <input type="checkbox"/> Laboratory Results <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> EKG Report <input type="checkbox"/> Billing Record <input type="checkbox"/> History & Physical
<b>PURPOSE</b>	<input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request  <input type="checkbox"/> Other (specify reason): _____
<b>INFORMATION TO BE SENT TO</b>  <i>All information must be filled out completely to process your request.. If not your request will be delayed</i>	Company, Person, or Facility Name _____ Phone Number _____  Address Line 1 _____ Fax Number _____  Address Line 2 _____  City _____ State _____ Zip Code _____

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.

I may refuse to sign this authorization form. I understand that Gavilan Peak Family Practice will not condition or deny treatment on my signing this authorization. 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. Gavilan Peak Family Practice's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, **it will expire 12 months from the date signed** or as specified: \_\_\_\_\_.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Gavilan Peak Family Practice, 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.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Legal Representative

\_\_\_\_\_  
 Relationship to Patient **or**  
 Description of Authority to Act for Patient

<b><u>For Healthcare Use Only</u></b>		
<b>Date Received:</b> _____	<b>Date Sent:</b> _____	<b>Processor:</b> _____