

**John C. Lincoln in Anthem**  
 3648 W. Anthem Way, A100  
 Anthem, AZ 85086  
 Phone: 623-434-6444  
 Fax: 623-434-6448

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

I authorize the following Physician to disclose the following information from the health record of:

Physician Name \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

PATIENT IDENTIFICATION  <i>All information must be filled out completely to process your request</i>	Patient Name _____		Date of Birth _____
	Address _____ City _____ State _____ Zip _____		Phone Number _____
Dates of Service: From _____ To _____			
INFORMATION REQUESTED	<input type="checkbox"/> Office Visit Note(s) <input type="checkbox"/> Laboratory Results <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Report <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Billing Record	<input type="checkbox"/> Specify: _____
	PURPOSE <input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request <input type="checkbox"/> Other (specify reason): _____		
INFORMATION TO BE SENT TO	_____ Ludmila Pyter-Kabat, MD                      _____ Robert J. Allen, MD _____ Kelly L. Tracey, DO                                      _____ Rebecca Matthews, FNP		
	John C. Lincoln Health Center in Anthem 3648 W Anthem Way, A100 Anthem, AZ 85086		Phone: 623-434-6444 Fax: 623-434-6448

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 1 year 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

**For Healthcare Use Only**

**Date Received:** \_\_\_\_\_ **Date Sent:** \_\_\_\_\_ **Processor:** \_\_\_\_\_