

Physician Group OF ARIZONA, INC.

Surgical Weight Loss Solutions at Tempe St. Luke's

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information: _____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Please name all person(s) we can contact and/or discuss your medical information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Following HIPAA patient confidentiality regulations, please check how you would like us to address you:

___ Mr. And/Or ___ First Name

___ Mrs. ___ Last Name

___ Miss ___ Other _____

___ Ms.

Signature: _____ Date: _____