PIERPONT FAMILY MEDICINE (Full Circle Health)
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ______________________ (patient name), authorize the following physicians and/or staff to

RELEASE MY RECORDS FROM (please include mailing address and telephone numbers)

Pierpont Family Medicine, LLC (Full Circle Health)	OR	______________________
4838 E. Baseline Road #103		______________________
Mesa, AZ 85206		______________________
phone: 480.926.8000		______________________
fax: 480.926.3445		______________________

AND SEND RECORDS TO:

______________________	OR	Pierpont Family Medicine, LLC (Full Circle Health)
______________________		4838 E. Baseline Road #103
______________________		Mesa, AZ 85206
______________________		phone: 480.926.8000
		fax: 480.926.3445

Information to be Used or Disclosed	All patient records including, but not limited to: doctors notes, lab test results, mental health/alcoholism/ drug abuse treatment, etc.
Purposes of Disclosure	Physician review. Other: ______________________
Expiration Date of Authorization	This authorization is effective through 01/01/2100 unless revoked or terminated by the patient or patient's personal representative.
Right to Terminate or Revoke Authorization	You may revoke or terminate this authorization by submitting a written revocation to Pierpont Family Medicine
You may refuse to sign this authorization.	Effect of Refusing Authorization If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for purposes of treatment, payment, or supporting the day-to-day operations of the practice. If you refuse to sign this authorization you may not be eligible for or receive research-related treatment or treatment that you have requested for the purpose of disclosure to others including: Treatment conditioned on authorization.

Print Patient Name: ______________________ DOB: ______________

Signature of patient or Personal Representative: ______________________ Date: ______________

Print Patient Representative Name: ______________________ Date: ______________

Patient Representative Relationship to Patient ______________________