TO AUTHORIZE:

I, ___________________________________ DOB: _______________________________
(PRINT PATIENT'S NAME)

Release Records To: ____
(PRINT NAME OF MEDICAL OFFICE(S) AUTHORIZED)

____
(PRINT PHONE NUMBER OF MEDICAL OFFICE(S) AUTHORIZED)

____
(PRINT FAX NUMBER OF MEDICAL OFFICE(S) AUTHORIZED)

____
(PRINT ADDRESS OF MEDICAL OFFICE(S) AUTHORIZED)

TO RECEIVE AND/OR REVIEW ALL MEDICAL RECORDS, BUT NOT LIMITED TO: DOCTORS NOTES, LABTEST RESULTS, MENTAL HEALTH/ALCOHOL DRUG ABUSE TREATMENT, ETC.

I UNDERSTAND THAT I MAY CHANGE OR REVOKE THIS AUTHORIZATION AT ANY TIME BY SIGNING THE BOTTOM PORTION OF THIS FORM.

DATE: ______________________________

PATIENT'S SIGNATURE: ____

TO REVOKE:

I, __________________________________ DOB: _________________________
(PRINT PATIENT'S NAME)

REVOKE ALL AUTHORIZATIONS AND PREVIOUS GRANTED TO:

____
(PRINT NAMES OF PERSON/PERSONS YOU ARE WITHDRAWING AUTHORIZATION FROM)

TO RECEIVE ANY/OR REVIEW ALL MEDICAL RECORDS, DOCUMENTATION, BILLING, AND ANY/ALL OTHER RECORDS MAINTAINED BY FULL CIRCLE HEALTH REGARDING MYSELF. I UNDERSTAND THAT THIS FORM, ONCE SIGNED, CANNOT BE OVERTURNED UNLESS A NEW FORM IS SIGNED.
I AGREE THAT I WILL NOTIFY THE OFFICE IF I WISH TO MAKE ANY CHANGES TO THESE AUTHORIZATIONS.

DATE: ____

PATIENT'S SIGNATURE: ____

4838 E. BASELINE RD. STE 103
MESA, AZ 85206
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F) 480-926-3445