Authorization for Release of Protected Health Information

Patient Name:_____ Date of Birth: _____Last 4 of SSN: _____

I authorize and request _____, to release the following protected health information (PHI) for the patient listed above to:

Person/ Facility: _____

Address:_____

Phone:_____Fax: _____

Email: _____

Information to be Included in Disclosure:

Date(s) of Service authorized to be released: _

- £ Summary Health Information (Clinic Notes, Laboratory Reports, Radiology Reports)
- £ Demographic Paperwork (Name, Date of Birth, Medical Record Number, Address, Phone number)
- £ Laboratory Reports
- £ X-ray (disc copy)
- £ CMS-1500, UB 04, HCFA-1500
- £ Itemized bill

This authorization shall cover Leading MDs and all of their respective employees, workforce, and business associates. This authorization may be revoked at any time, provided that the revocation is executed in writing to the Leading MDs Compliance Officer at 13555 W. McDowell Rd. #205 Goodyear Az, 85395 Revocation will not affect any disclosures acting upon by this disclosure and prior to request for revocation. Information disclosed pursuant to this authorization may be re-disclosed and is no longer protected by federal and state privacy rules. Authorization of disclosure of the above information is voluntary and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

Signature of Patient/ Patient Representative*: _____ Date: _____

*If signature is for a patient representative, please describe relationship to patient: _____

Please send to:

Leading MDs | Medical Records Department
13555 W. McDowell Rd #205 Goodyear, Az 85395
Fax: 949.577.4738