Laurie Thomas MD
1601 N Tucson Blvd #2
Tucson, AZ 85716
P (520) 400-8223
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Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Name _____ Today's Date _____
Patient's DOB _____

By signing, I authorize _____ (<---Previous doctor's name
_____ and contact information)
_____

to disclose certain protected health information (PHI) about me to

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I hereby consent to the release of the following individually identifiable health information about me:icd

Progress notes - last 2 years
Test results - last 2 years
Problem list, Medications, Allergies, Immunizations, QIS (Health Care Maintenance)

In addition, I hereby consent to release of the following **specialized information**:

____**Drug/alcohol treatment** (Please initial each section authorized)
____**Genetic information**
____**HIV/AIDS information**
____**Mental health treatment**
____**STD/Communicable disease information**

This authorization is voluntary. The information will be used or disclosed at my request. I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Signed: _____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Relationship to Patient