Foothills Family Care, P.L.C.
4530 East Ray Road, Suite 150
Phoenix, AZ 85044
Phone: 480-785-4775 Fax: 480-785-0908

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Rebecca L. Goldman, M.D.
Rebecca F. Moran, M.D.

Patient's Name: _____ Birthdate: _____

Address: _____

Purpose of Disclosure: _____

☐ Please release **all** medical information which may include **psychiatric counseling, drug or alcohol treatment, HIV/AIDS related information and confidential communicable disease related information.**

☐ Please release the following specific information: _____

_____

_____

_____

I hereby authorize: _____
(NAME OF COMPANY, PERSON, FACILITY)

_____ to release all of the requested
(ADDRESS)

information relative to my treatment and care to: _____
(NAME OF COMPANY, PERSON, FACILITY)

_____
(ADDRESS)

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it is signed. Any further disclosure of medical record information by the recipient(s) is not authorized without specific written consent of the person to whom it pertains.

_____ _____
(SIGNATURE OF PATIENT) (DATE)

_____ _____
(SIGNATURE OF OTHER AUTHORIZED PERSON) (DATE)