☐ STAT (If Marked, Please Send STAT)

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name:	DOB:

I Authorize:	
Phone:	Fax:

To release my confidential health information to the following person/organization:

☐ Dr. Anna Boron ☐ Dr. James Deer
Arkangel Endocrinology and Diabetes, PLLC
2222 E. Highland Ave Suite 221 Phoenix, Arizona 85016
Phone: 602-675-1213 Fax: 602-935-3069

Fax Attention To: ______________________________

Purpose of Release: (Check all that apply)
☐ Continuation of Care ☐ Disability ☐ Insurance ☐ Personal Use ☐ Other: ____

Person/ Organization requesting records: (Check all that apply)
☐ Patient/ Parent/ Patient Representative/ Legal Guardian ☐ Physician/Physicians Practice/Hospital ☐ Other: ___________________

Information to be disclosed:
☐ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ **Only the following records or types of health information:**
- ☐ Laboratory/ Pathology Testing: ____
- ☐ Medical Imaging: ____
- ☐ Consult Notes: ____
- ☐ Procedure/Surgery Notes: ____
- ☐ Other: ____

Name:	Signature:	Date:

If individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative:	Signature:
Relationship to Individual:	Date:

This authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris Short Act.