

MORNING STAR OB/GYN
3011 S. LINDSAY RD, STE 113
GILBERT, AZ 85296
TELEPHONE: (480) 355-8525 FAX: (480) 355-3115

Authorization To Obtain Medical Records/Information

Patient Name: _____ Provider: Dr. Clint J. Leonard
Address (include City, State, and zip): _____
Home Phone: _____ Work Phone: _____
Social Security Number: _____ Date of Birth: _____

I authorize Clint J. Leonard, MD to obtain medical records / information from:

Name	Phone	Fax	
<hr/>			
Address	City	State	Zip Code

Please release the following information from my medical record:

_____ Complete Record	_____ Laboratory Report(s)	_____ Radiology Report(s)	_____ Other _____
_____	_____	_____	_____
Date(s) of service	Date(s) of service	Date(s) of service	Date(s) of service

Send to: Clint J. Leonard, MD
3011 S. Lindsay Rd. Suite #113
Gilbert, AZ 85296
Ph: 480-355-8525 Fax: 480-355-3115

I hereby consent to the release of records pertaining to treatment/diagnosis of the following:

- _____ Confidential Alcohol or Drug Abuse-Related Information (as defined in 42 CFR Section 2.1 EP SEQ)
- _____ Confidential HIV-Related Information (as defined in A.R.S. Section 36-661)
- _____ Confidential mental Health Diagnosis/Treatment Information
- _____ Confidential Communicable Disease-Related Information (as defined in A.R.S. Section 36-661)

Except as follows: _____

The purpose of this request is for: *(please check ALL that apply)*:

_____ Further Medical Care	_____ Insurance	_____ Disability/Worker's Compensation
_____ Personal Care	_____ Legal	_____ Other: _____

Expiration of Authorization: I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below (sixty [60] days for drug/alcohol abuse treatment records).

Right of Revocation: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do this in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Disclosure of Information: I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected.

Marketing Purposes: I understand this information will in no way be used for marketing purposes.

Patient Signature _____ Date _____

Parent/Legally Authorized Representative _____ Relationship to Patient _____ Date _____

Signature of Witness _____ Information Prepared & Released By _____ Date _____

In the case of a patient who is physically unable to sign this authorization, he/she should place and "X" on the signature line and have his/her assent witnessed.