NORTH
SCOTTSDALE
FAMILY MEDICINE

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Designated Agent–Release of Information Authorization

Patient Name: ______________________________ **Birthdate:** ______________

I hereby authorize **North Scottsdale Family Medicine Associates** to release my medical information to:

This **Person:** ______________________________ *Full Name required*

who is: ______________________________ *Relationship to Patient*

at this **Address:** ______________________________ *Full Mailing Address required*

____

and **Phone Number:** (   ) ______________________________ *(Area Code) + Phone Number*

☐ *Initials* — I hereby consent to the release of records pertaining to treatment and/or diagnosis of the following:

- *Confidential Alcohol or Drug Abuse related information;*
- *Confidential HIV-related information;*
- *Confidential Mental Health Diagnosis and/or Treatment information;*
- *Confidential Communicable Diseases related information.*

☐ *Initials* — I understand that I may revoke this Authorization at any time, except to the extent allowed by law.
(Any use or disclosures made before the patient revoked the Authorization are not affected.)

☐ *Initials* — I also understand that information used or disclosed may be subject to redisclosure by the Designated Agent identified above, and no longer be protected by the privacy rule.

This Authorization Form ***will not expire*** unless **revoked** by the Patient **in writing**.

______________________________ ______________
SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE — DATE

______________________________ ______________________________
WITNESS FULL SIGNATURE (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC) — RELATIONSHIP STATUS IF SIGNED BY ANYONE OTHER THAN PATIENT