VALLEY ENT
superior medical care, right in your neighborhood

5110 E. Warner Rd. • Suite 100 • Phoenix, AZ 85044
2081 W. Frye Rd. • Suite 100 • Chandler, AZ 85224
P. 480-753-1459 • F. 480-753-5311 • www.azvent.com

Jeffrey McKenna, MD — Board Certified Otolaryngology
James Chuang, MD — Board Certified Otolaryngology
Maulik Shah, MD — Board Certified Otolaryngology
Yvonne Richardson, MD — Board Certified Otolaryngology

Lindsay Hendrickson, FNP-C
Trisha Muñoz, Au.D.
Kristina Garza, Au.D.
Linae Smith, M.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, _____, hereby voluntarily authorize the disclosure of information from my health records.
(Name of Patient)

Patient Name: _____ Patient's Date of Birth: _____

Patient's Address_____ City _____ State _____ Zip Code _____

Home Phone _____ Cell or Work Phone _____

Information Requested:

X The complete medical records pertaining to my treatment and care *(Excludes Psychotherapy Note)
Psychotherapy Notes must be on a separate request form.

_____Specific test, labs, notes or date of service _____

Purpose of Release: _____
(Patient's request, dispute, referral, other)

Records from:	Records to:
DR. Valley ENT/Chandler	DR. Maulik B. Shah / Canyon Sky ENT
Phone: 480-753-1459	Phone: 480-676-3322
FAX: 480-753-5311	FAX: 480-676-3523

1. I understand that this authorization will expire on (insert date) _____.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Valley ENT P.C. in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative — Date

_____ _____
Print Name of Patient Representative — Relationship to Patient

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM