AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH-RELATED INFORMATION
THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

NAME:_____ DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf (my "Providers") to disclose my entire medical record and any other personal health information concerning me to ***Sierra Vista Internal Medicine, P.L.L.C.*** This includes information on the diagnosis and/or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By signing below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization, and I instruct my Providers to release and disclose my entire medical record without restriction.

MAIL TO: SIERRA VISTA INTERNAL MEDICINE, P.L.L.C
DAVID J. KNAPP, MD
75 COLONIA DE SALUD
SUITE 200A
SIERRA VISTA, AZ 85635
FAX TO: (877) 771-1056

I understand that this Authorization is voluntary and made to confirm my direction. I understand that ***Sierra Vista Internal Medicine, P.L.L.C. ("Provider")*** has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and safeguard the privacy of patient health information.

This release is being presented to _____
_____
_____
_____
FAX: _____

Signature: _____ **Date:** _____
(if under 18, Parent or Legal Representative)

Name: _____ **Title:** _____