MORNING STAR OB/GYN
3499 S. MERCY ROAD
GILBERT, AZ 85297
TELEPHONE: (480) 355-8525 FAX: (480) 355-3115

Authorization To Release 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 *release* medical records / information *to*:

_____
Name Phone Fax

_____
Address City State Zip Code

Please forward 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

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.