Heavens Medical PLC

105 S Delaware Dr, Ste 1 & 2 • Apache Junction, AZ 85120 • (480) 646-1001 Fax: (480) 646-1002

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:	Date of Birth:
City/State/Zip:	Social Security #:

I authorize Heavens Medical, PLC to:

☐ Request ☐ Release

Healthcare Information of the patient named above from / to:

Name (Physician, Hospital, Family Member, Self)

City/State/Zip:

Phone:	Fax:

For the Purpose of:

Other: _____

Type and amount of informtion to be disclosed is as follows:

- ☐ Complete Medical Record
- ☐ Complete Medical Record from _____ to _____
- ☐ Laboratory Results from _____ to _____
- ☐ Billing Information
- ☐ Other: _____

I understand that the medical information released by this authorization may include confidential information concerning my treatment of physical and/or mental illness, alcohol/drug abuse, HIV/AIDS and past medical history.

I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Heavens mediccal, PLC cannot condition treatment, payment enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient, Guardian or Authorized Personal Representative	Date	Witness (office personnel)
/		
Patient, Guardian or Personal Represent. Name (print) and Relationship (Please attach legal documentation of authority)	Date	Witness (office personnel)