Mercy Grace Private Practice|1720 E Boston St. Suite 101|Gilbert, AZ 85295
P|480-745-3702 F|480-745-3709

Mercy Grace Private Practice
Authorization to Release Medical Information

Patient Name: _____

DOB: _____ Date: _____

Purpose of Disclosure: **CONTINUED PATIENT CARE**

I authorize the release of records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug abuse from the following facilities:

I hereby authorize: _____
Physician/Facility Name

_____
Address, City/State/Zip

_____
Phone Number

To release all the above requested information relative to my treatment and care to:

Mercy Grace Private Practice
Physician/Facility Name

1720 E Boston ST., Suite 101, Gilbert, AZ 85295
Address, City/State/Zip

480-745-3702 / Fax 480-745-3709
Phone Number

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically one year from date of which is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of the disclosures.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Signature Date

If patient is a minor and information is released regarding treatment for Alcohol and/or Drug abuse, both the patient and parent or legal guardian must sign.