West Valley Internal Medicine, L.L.C.

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AUTHORIZATION TO DISCLOSE INFORMATION

I, ______________________________ DOB ____________________ ,
(Patient Name)
hereby authorize West Valley Internal Medicine to discuss my personal medical records with:

____
(Spouse, Sibling, etc.- EXCLUDING MEDICAL PROFESSIONALS

____
(Relationship)

☐ I wish to release ***ALL*** aspects of my record to the above mentioned person(s).

☐ I wish to release **Limited** aspects of my record to the above mentioned person(s).
Please limit the information to:

- ☐ Lab Results
- ☐ Imaging Results
- ☐ Prescriptions
- ☐ Referral Information
- ☐ Office Visit Notes
- ☐ Miscellaneous Documents

☐ At this time **I do not wish to authorize** West Valley Internal Medicine to discuss my records with anyone other than myself.

I understand that I may revoke this release in writing at any time at my discretion.

______________________________   ______________________________
Signature   Date

______________________________   ______________________________
Office Staff Witness   Date