

# West Valley Internal Medicine, L.L.C.

Sudeep S. Punia M.D.    Mohammed I Jamil, M.D.    Michael F. Kleven, D.O.  
M. LeBourhis-Hannallah, M.D.

## 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:
- |  |  |
|--|--|
| <input type="checkbox"/> Lab Results     | <input type="checkbox"/> Referral Information    |
| <input type="checkbox"/> Imaging Results | <input type="checkbox"/> Office Visit Notes      |
| <input type="checkbox"/> Prescriptions   | <input type="checkbox"/> 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

17218 North 72<sup>nd</sup> Drive, Suite 100 \* Glendale, AZ 85308  
12133 West Bell Road, Suite 101 \* Surprise, AZ 85374  
4110 North 108<sup>th</sup> Avenue, Suite 101 \* Phoenix, AZ 85037

Phone: (623) 334-8670 \* Fax (623) 334-8675  
Phone: (623) 815-9073 \* Fax (623) 815-9201  
Phone: (623) 218-0780 \* Fax (623) 218-0786

[www.westvalleycare.com](http://www.westvalleycare.com)

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