General Medical Release Form

Authorization For Use or Disclosure of Imaging Information

This authorization for use or disclosure of my health information is required by state and federal law.

PATIENT'S NAME _____ _____ DOB: _____
Last First MI

Daytime Telephone Number _____

I Hereby Authorize The use or Disclosure of My health Information

_____
(name of person or organization releasing information)

_____
Street Address

_____
CITY STATE ZIP CODE

To Release my Health Information To:

Performance Insurance Benefits
(name of person or organization releasing information)

20827 N. Cave Creek Rd., Ste. 102
Street Address

Phoenix AZ 85024
CITY STATE ZIP CODE

This Authorization Applies To The Following Information:

☒ All records ☐ Lab ☐ Imaging Reports ☐ Immunization

☐ Other: _____

The Recipient May Use My Health Information Only For The Following Purpose:

(Please Specify) ANY

A specific authorization is required to release information regarding the following:

	YES	NO	INITIALS
HIV Information	☐	☐	_____
Drug/Alcohol Information	☐	☐	_____
Mental Health Information	☐	☐	_____

I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. COPY Requested: ☐ Yes ☐ No

Patient Signature _____ Date: _____
Patient/Personal Representative Signature _____
Relationship to Patient _____