Date: _____

I herby authorize:

_____

to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal or state law. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

To release the following information from my medical records:

1. Brief summaries of medical history, clinical findings and diagnosis
2. Laboratory Reports
3. X-ray Reports
4. Discharge Summaries
5. Consultations
6. Other: _____

To: _____

_____

_____

_____ _____

Signature Date of Birth

_____ _____

Print Name Social Security Number

Brett Roeder DPM

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Phone 480 507-7560 Fax 480 507-7509

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