Medical Records Release Authorization

Patient Name: _____ Date of Birth: _____

Other names used by patient: _____ SSN: _____

I authorize the following physician:

Physician name: _____

Address: _____

Phone #: _____ Fax #: _____

To release COMPLETE health records to:

G & K MEDICAL ASSOCIATES, P.C.
10450 W MCDOWELL ROAD, SUITE 101
AVONDALE, AZ 85392
PHONE #: 623-935-1000
FAX #: 623-935-1022

I understand that specific information to be released may include AIDS or HIV, alcohol and/or drug abuse, and mental health. Unless otherwise indicated this authorization will never expire from the date signed or as specified: _____ the physician and the employees are release form any legal responsibility or liability for disclosure of the above information to the evoked in writing at any time, except to the extent that an action has been taken in reliance on this authorization for the purposes stated above.

_____ _____

Patient Name Date

_____ _____

Patient Signature Relationship to patient