Feliz Care Centers

Medical Release Authorization

Previous Medical Provider and or Facility Name: ____

*Address*____

*Phone*____

I authorize you to release photocopies of confidential medical records to possession or control of Feliz Care Centers LLC., it's employees or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFE SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS AND TREATMENT INFORMATION.

Patients full name:________________________________ Date of Birth:_________________________

This authorization may include items protected by code of federal regulations, 42 CFR, part 2, and other provisions set forth in A.R.S. Sections 36-661. This request is in compliance with the health insurance portability accountability act of 1996 (HIPAA).

The information requested is to be used for the purpose of:_____________________________________

____

I specifically request the following type of information be released:_______________________________

____

This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance of this consent prior to revocation. In any event, this authorization expires 12 months the date of signature.

Patient_____________________________________ Date_______________________

Signature of Witness____