Panda Medical Associates, LLC
6760 West Thunderbird Road, Suite E100
Peoria, AZ 85381-5048
623-241-9028 (office)623-241-9029 (fax)

HIPAA Compliant Request for Information

All fields on this form must be completed.

MY INFORMATION: Patient

Name: _____Address: _____
Phone: _____ City, State, Zip: _____
Date of Birth: _____

INFORMATION REQUESTED: I instruct the above entity to release a copy of the following information (Check One):

____ Comprehensive Care Summary (covering 24 months) ____Entire record
____ Specific records: _____

I hereby authorize Panda Medical Associates, LLC to release my Protected Health Information (PHI) to the following entity or person:

Name: _____Address: _____
Phone: _____ City, State, Zip: _____
Fax: _____

FORM & FORMAT OF RECORDS: I request the copies of records be delivered as follows (Check One):

_____Fax the records to the number indicated above.
_____Mail to the address indicated above.
_____I will pickup at the office during normal business hours.

REASON FOR DISCLOSURE: I am requesting my PHI to be disclosed for the following purpose:

_____

SENSITIVE INFORMATION DISCLOSURE: HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information within the dates specified above are to be released through this authorization unless otherwise checked below:

DO NOT RELEASE: (Check all that apply) ___HIV___Behavioral Health___Drug/Alcohol

I have given my consent freely, voluntarily and without coercion. I understand that any releases which were made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original. This authorization is valid for 90 days. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to: Panda Medical Associates, LLC at 6760 West Thunderbird Ave., Suite E100, Peoria, Arizona 85381. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization. I may not be required to sign this Authorization as a condition to be obtaining treatment or payment or my eligibility for benefits. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date