Consent for Release of Information

I _____,

Date of Birth : _____

Authorize:

Rob Ashby, MD, PLC
3636 Crossings Drive
Prescott, AZ 86305
Phone: (928) 778-5097
Fax: (407) 633-7536

To ☑ Release to ☑ Receive from ☑ Communicate by voice or writing or exchange medical records.

Concerning: ☑ All information or limited to (check all that apply): ☐ Medical, ☐ Imaging

☐ Laboratory ☐ Drug and Alcohol ☐ Psychiatric ☐ Infectious disease.

With: _____

_____

_____

_____

_____

For the purpose of:

☑ Coordination of care

☐ Other_____

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon ☑ termination of care or: ☐ _____(specific date, event, or condition).

Signature: _____ ☐ Electronically Signed

Date (on which this consent is signed): _____

Name and relationship if signed by other than the patient: _____