



AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION

PATIENT NAME: LAST FIRST

DATE OF BIRTH

I HEREBY AUTHORIZE:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO RELEASE INFORMATION TO:  
**MAYA BROWNSBERGER, M.D.**  
**OPTIMAL HEALTH & AESTHETICS**  
**1360 NORTH RIM DRIVE**  
**FLAGSTAFF, AZ 86001**  
**(928) 214-7005**  
**(928) 214-8855 (FAX)**

PURPOSE OF DISCLOSURE:

- CONSULTATION
- MEDICAL CARE
- FOR PERSONAL USE
- OTHER (SPECIFY):

INFORMATION TO BE RELEASED

BETWEEN THE DATES OF:

- H&P EXAM/INITIAL EVAL \_\_\_\_\_
- PROGRESS NOTES \_\_\_\_\_
- DISCHARGE SUMMARY \_\_\_\_\_
- CONSULT \_\_\_\_\_
- LAB REPORTS/PATHOLOGY \_\_\_\_\_
- X-RAY REPORTS \_\_\_\_\_
- X-RAY FILMS/MRI \_\_\_\_\_
- CORRESPONDENCE \_\_\_\_\_
- OTHER (SPECIFY CONTENT AND DATES):

\_\_\_\_\_  
\_\_\_\_\_

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I UNDERSTAND THE EXPIRATION DATE OF THIS AUTHORIZATION IS ONE YEAR.
- UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PROVIDING ORGANIZATION IN WRITING, AND IT WILL BE EFFECTIVE ON THE DATE NOTIFIED EXCEPT TO THE EXTENT ACTION HAS ALREADY BEEN TAKEN.
- UNDERSTAND BY AUTHORIZING THIS USE OR DISCLOSURE OF INFORMATION THERE WILL BE NO CONDITIONS PLACED ON MY HEALTH CARE OR PAYMENT FOR MY HEALTH CARE.
- UNDERSTAND I WILL RECEIVE A COPY OF THIS FORM AFTER I HAVE SIGNED IT.
- I UNDERSTAND THAT I MAY BE REQUIRED TO PAY A FEE FOR RETRIEVAL AND PHOTOCOPYING OF RECORDS AND/OR SUPERVISING INSPECTION OF MEDICAL RECORDS.

SIGNATURE OF PATIENT, PARENT OF MINOR, OR PERSONAL REPRESENTATIVE

RELATIONSHIP

DATE \_\_\_\_\_