GRAND MEDICAL ASSOCIATES

Neena Uppal, M.D.
Pritpal Sandhu, M.D.
Jamie Brockman, PA-C

FAMILY/ FRIEND ROI

Patient Name:______________________________ Date of Birth:________________________

INFORMATION TO BE RELEASED:

- ☐ 1 Year of Records ONLY
- ☐ Other:__________________

I AUTHORIZE THE RELEASE AND DISCLOSURE OF THE ABOVE INFORMATION TO THE FOLLOWING MEMBERS OF MY FAMILY AS FOLLOWS:

Name:________________________/Relationship:____________/ Phone Number:_______________

Name:________________________/Relationship:____________/ Phone Number:_______________

Name:________________________/Relationship:____________/ Phone Number:_______________

Name:________________________/Relationship:____________/ Phone Number:_______________

This authorization shall expire 180 days from the date below unless otherwise specified here:____________________________________. I understand I may withdraw my authorization at any time by submitting a written request to Grand Medical Associates. I understand any revocation is not effective to the extent action has already been taken in reliance on this authorization. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law. This authorization is not intended to affect a patient's liability to receive medical care.

Alcohol and Drug Abuse Treatment, if checked above, to the extent my medical record contains information regarding alcohol or drug treatment that is protected by federal law, I authorize the disclosure of such information or record.

HIV/AIDS Information, if checked above, to the extent my medical record contains information regarding my HIV/AIDS status, treatment or testing, I authorize the disclosure of such information.

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Signature of Patient or Legal Representative Date

14674 W. Mountain View Blvd. Ste 200
Surprise, Arizona 85374

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Fax 623-544-6861

grandmedicalassociates.com