GRAND MEDICAL ASSOCIATES

Amardeep Majhail, M.D.
Neena Uppal, M.D.
Pritpal Sandhu, M.D.

Joshua Kohl, PA
Taelyn Carrizales, PA
Danyelle Harbauer, PA
Nayla Mansoor, PA

Patient Name:_____ **Date of Birth**:_____

INFORMATION TO BE RELEASED:

☐ 1 Year Only (OV Notes, Labs, Imaging Reports)

☐ Other:_____

☐ Last Mammogram, Dexa, Colonoscopy

****WE DO NOT ACCEPT RECORDS ON CDs****

I authorize the release and disclosure of the above information as follows:

REQUESTING RECORDS FROM:		**PLEASE SEND RECORDS TO:**	
Person/Facility:	_____	Person/Facility:	GRAND MEDICAL ASSOCIATES
Address:	_____	Address:	14674 W MOUNTAIN VIEW BLVD #200
	_____		SURPRISE, AZ. 85374
Phone:	_____	Phone:	623-544-6860
Fax:	_____	Fax:	623-544-6861

******YOU MUST PROVIDE A FAX NUMBER SO THAT WE MAY OBTAIN YOUR RECORDS******

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

_____
Signature of Patient of Legal Representative Date

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Patient Name:_____ Date of Birth:_____

INFORMATION TO BE RELEASED:

- ☐ Entire Record (1 year)
- ☐ Other:_____

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

Name/Relationship:_____

Name/Relationship:_____

Name/Relationship:_____

Name/Relationship:_____

Name/Relationship:_____

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.

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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.

_____

Signature of Patient or Legal Representative Date

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

Tel. 623-544-6860
Fax 623-544-6861

grandmedicalassociates.com