Consent for Release of Information

I _____,

Date of Birth : _____

authorize:

Rob Ashby, MD, PLC
115 S McCormick St #2
Prescott, AZ 86303
(928) 778-5097 Phone
(407) 633-7536 Fax

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

Concerning: All information including medical, drug, alcohol, psychiatric and 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: _____(specific date, event, or condition) or upon termination of care.

6. Date (on which this consent is signed): _____

7. Signature of patient _____

8. Signature of parent or guardian (where required)
_____
9. Signature of person authorized to sign in lieu of the patient (where required)
_____
10. Printed Name of Person Signing this Request: _____