

**REQUEST FOR RECORDS AND/OR AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

I authorize _____
_____ to disclose Protected Health Information
("PHI") from the health records of:

Patient name: _____ Date of Birth: _____

Address: _____

Phone number: _____ Social Security No.: _____

I authorize PHI for the last ten years to present to be disclosed to REES & LEVY, 4771 E. Camp Lowell Drive, Tucson, Arizona, 85712 (520) 327-7775, (520) 327-3239 FAX and/or DocuTrak, Inc.

The following information is to be disclosed: Any and all medical records reflecting the care and treatment rendered by said health care provider over the last ten years. This release includes copies of any and all medical records, x-ray reports, notes, itemized billing statements, and other similar documentation.

The purpose of this disclosure is: All medical records and bills will be used in connection with litigation.

I authorize the provider to use or disclose information related to:

- AIDS/HIV and other Communicable Disease
- Behavioral Health Care/Psychiatric Care
- Alcohol and/or Drug Abuse Treatment
- Genetic Testing Information

I understand that the health care provider will not condition treatment on my signing this authorization. The health care provider will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form.

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the health care provider's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the recipient of the initial authorization. However, the undersigned may not revoke the authorization retroactively for information released.

This authorization shall be considered invalid after six months (or 60 days with respect to drug and alcohol abuse records) from the date of signing, unless a different date/event is specified: December 30, 2007.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

Patient,

Date