Medical Records Release

I hereby authorize the use or disclosure of medical records to the named individual as described below:

____

Patient Name | Date of Birth | Social Security Number

____

Address (street, city, state & zip) | Phone Number

I authorize the following information to be disclosed:
(Please check all that apply)

- ☐ Complete Medical Records
- ☐ Progress Notes
- ☐ Labs
- ☐ Xray / Imaging Reports
- ☐ Other ______________________

I authorize and direct you to:
Furnish records ***TO*** Desert Foothills Family Medicine from:
Release records ***FROM*** Desert Foothills Family Medicine to:

Reason for Request:
(Please check all that apply)

- ☐ Transfer of Care
- ☐ Continuity of Care
- ☐ Other______________________

IF OVER <u>TEN</u> PAGES
PLEASE MAIL RECORDS TO
5505 W CHANDLER BLVD B13
CHANDLER AZ 85226
DO NOT FAX

____

Physician/ Hospital Name | Phone Number | Fax Number

____

Address (street, city, state & zip)

Desert Foothills Family Medicine
Jessica A. Blanco, M.D.
Maura Tardif, PA-C
5505 W. Chandler Blvd. Suite B13
Chandler, AZ 85226
Phone (480) 361-4780 Fax (480) 361-4781

I understand the information in my record may contain information related to HIV/Aids, Communicable Disease, Mental Health and / or Alcohol / Drug abuse. I understand I may revoke this authorization at any time. I understand that me revocation must be in writing. I understand the revocation will not apply to information already based on this authorization. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this for to receive medical treatment.

A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Patient/Responsible Party Signature:____

Witness:____ Date:________________________________