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MEDICAL RECORD RELEASE FORM

Patient Name: _____ DOB: _____

Address: _____

Phone: _____ Primary Care Physician: _____

Send Medical Information TO:

PAGE FAMILY HEALTH & WELLNESS
5030 S. MILL AVE, STE D-12 TEMPE, AZ 85282
PHONE: 480-894-2823
FAX: 480-756-6663 or 480-664-0828 (STAT REQUEST)
CIRCLE ONE

Request Medical Information FROM:

Name of person or medical entity to send information

Address

Phone

Fax

RECORDS REQUESTED

Specific Dates Requested: _____ to _____

Specific Records Requested: _____

- All Medical Records
- Immunizations & Laboratory Results
- Radiology & Advance Testing Results
- Confidential HIV Information
- Mental Health Diagnosis & Treatment
- Medical Evaluation & Treatment

This authorization is effective for **90 days** unless revoked or terminated by the patient or the patient's representative. You may revoke or terminate this authorization by submitting a written revocation to **PAGE FAMILY HEALTH & WELLNESS**. Information that is disclosed under the authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Patient Signature: _____

Date: _____

This release authorizes the disclosure of records for 90 days from the signed date above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis and treatment for physical and/or mental illness, including treatment of alcohol and substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions.