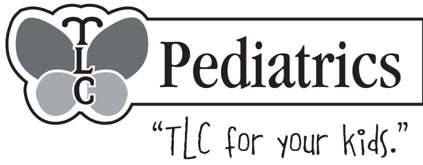

PATIENT RELEASE OF MEDICAL RECORDS
REQUEST FORM

Patient's Legal Name ______________________________ Patient's Date of Birth ____________________

Name of Parent or legal Guardian ____________________ Relationship to Patient ____________________

Facility you are releasing records from: ________________

Providers name: ______________________________ Address: ______________________________

Phone#: ______________________________ Fax#: ______________________________

I hereby request a copy of my medical records as detailed below:

☐ Full medical record held by this office

☐ Medical record for the period _________________________ through ______________________________

☐ A portion of medical record to include Problem List, Growth Charts, Immunization Record and Medication List.

☐ A specific portion/selection of the record as follows:

____

____

____

____

FOR THE PURPOSES HEREOF "MEDICAL RECORDS" SHALL INCLUDE:

1. ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET-SEQ.)
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION

Signature ____ Date ____________________

16611 South 40th Street, Suite 160
Phoenix, AZ, 85048
Fax: 480-940-8530
Phone: 480-940-8527