AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Please allow 72 hours to process your request.

Date of Request: _____ Date Records Needed: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Phone Number: (_____)_____ SS# _____

Specific Records to be Released: □ Imaging Reports □ Lab Reports □ Office Visit Notes □ All Records

□ Obtain From □ Release To

Name of Provider/Facility/Yourself: _____

Address: _____

City/State/Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____) _____

Date: _____

Signed By: _____ _____

Signature of Patient or Legal Guardian Print Patient's Name

_____ _____

Print Name of Legal Guardian, if applicable Relationship to Patient

Fax to: 480-436-6611 **Phone: 480-426-0767**