

**Medical Records Release Form**

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\_\_\_\_\_  
Patient First and Last Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient Email Address

\_\_\_\_\_  
Patient Phone Number

**I hereby authorize:**

**To release information to:**

\_\_\_\_\_  
Doctor/Clinic Name:

Health Matters

9180 E Desert Cove, Suite 105

\_\_\_\_\_  
Clinic Phone:

Scottsdale, AZ 85260

Phone: 480-993-3331

\_\_\_\_\_  
Clinic Fax:

Fax: 480-800-3240

**INFORMATION TO BE RELEASED (Please select one):**

- Complete Medical Records
  - Lab reports/documents/imaging from the past year
  - Provider notes, labs, and treatment plans from the last appointment
  - Other (specify content and dates): \_\_\_\_\_
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**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand the expiration date of this authorization is one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- I understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.

\_\_\_\_\_  
Signature of patient, parent of minor, or personal representative

\_\_\_\_\_  
Date

**AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**