Health Matters
AN INTEGRATIVE APPROACH TO FAMILY MEDICINE

Medical Records Release Form

Patient First and Last Name _____ Patient Date of Birth _____

Patient Email Address _____ Patient Phone Number _____

Doctor/Clinic Name: _____

Clinic Phone: _____

Clinic Fax: _____

Health Matters
9180 E Desert Cove, Suite 105
Scottsdale, AZ 85260
Phone: 480-993-3331
Fax: 480-800-3240

I hereby authorize _____

To release information to _____

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): _____

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