Premier Care for Women

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(623) 584-0800 Office * (623) 584-0312 Fax * www.premiercare4womenaz.com

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Medical Records Release Authorization

I, _____
hereby authorize Premier Care for Women to release the following information on:

Patient Name: _____ Birth date: _____
Patient Address:
_____
Phone Number: _____

Please check all information to be released: (Allow minimum of 3 business days for copying)

† Entire record set † Problem list † Registration record
† Medication list † Laboratory reports † Physician notes
† Imaging reports (ultrasound/mammogram)
† Other _____
Dates of treatment:
_____

Information shall be released (sent) to:
_____
Physician/Facility
Address:_____ Fax: _____

Purpose for release of records:
† 2nd Opinion/consult † Moving † Changing physicians
† For attorney † Personal use † Other: _____

1) I understand that my record may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status.

† Include these records † Do not include these records

2) I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days.

Fees:

I understand that a copying fee of twenty-five (25) dollars will be charged for records released directly to the patient. We do not charge for physician to physician transfer of medical records.

I authorize the following individuals to pick up my records:

_____

Must bring picture ID

Authorized signature: _____ **Date:** _____

Relationship to patient: † Patient † Legal guardian † Healthcare power of attorney

(Submit signed copy)