

Fountain Hills Family Practice, P.C.

13620 N. Saguaro Boulevard, Suite 100 • 480.816.3131 • Fax: 480.816.3136
www.fountainhillsfamilypractice.com

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize and request _____ to release medical records to:

Physician or contact name: _____

Company or practice: _____

Address: _____

City, State, Zip: _____

Please check one:

- I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, other sexually transmitted diseases drug and/or alcohol abuse, mental illness or psychiatric treatment. **OR**
- I do not give permission to release information regarding the diagnosis or treatment of HIV/AIDS, or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.

Name: _____ DOB: _____

SS#: _____ Telephone: _____

Address: _____

City, State, Zip: _____

Signature: _____ Date: _____

Witness Signature: _____ Date _____