Records Release Medical Authorization

Ahwatukee Family Medical Center
13838 S. 46th Place, Suite 320
Phoenix, AZ 85044
(480)759-5151 Phone
(480)940-8649 Fax

Patient's Name _____ DOB ____/_____/_____

Address _____

City _____ State _____ Zip _____

All Records _____ Labs Only _____ Other _____

Reason for request _____

I authorize you to:

_____ Furnish records TO Ahwatukee Family Medical Center FROM: _____

_____ Furnish records FROM Ahwatukee Family Medical Center TO:_____

Important notice per Health insurance Portability and Accountability Act (HIPAA): We can only copy, print, mail, or fax our records. We do not copy, print, mail, or fax other Doctor's medical records. Please contact that Doctor for records. I also authorize the release of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations. In addition, I understand that I may revoke this notice at anytime by notifying Ahwatukee Family Medical Center. I understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Office Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

I understand that my request will be processed within the time frame set by state law. I also understand that I am responsible for the cost of medical records for personal use. A HIPPA compliant company copies records every Friday. I desire this authorization to be in effect until _____. If not dated, expiration is 90 days from date of signature.

Print Name _____

Signature _____

Date _____