SCOTTSDALE INFECTIOUS DISEASES, PC

Medical Plaza I • 10250 N. 92nd Street, Suite 203 • Scottsdale, Arizona 85258

Phone: 480-949-2080 • Fax: 480-949-2091

Medical Records Release

Patient's Full Name_____

Date of Birth_____

TO: _____

Name (or title) and Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please disclose the following information (check all that applies):

____ All of my health information including, but not limited to, AIDS/HIV and other communicable disease information, Behavioral health Care/Psychiatric Care, Alcohol and/or Drug abuse Treatment, unless specifically excepted:

____ My health information relating only to the following treatment or condition_____

____My health information for the following date(s) of service: _____

____ Other (specify) _____

You may disclose the health information to:

Name (or title) and Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

_____Ok to fax medical records. (This fax is confidential, intended for named recipient only.)

The signature below authorizes the release of my medical records as checked above. A copy of this signature on this from is as valid as original.

_____ _____

Patient Signature or Patient's Legal Representative **Date**