East Valley Primary Care Physicians,PLC
4515 S. McClintock Suite 100
Tempe, Arizona 85282
(480) 820-1133 (480) 820-2175-fax

AUTHORIZATION FOR RELEASE OF RECORDS

Patient's Name_____DOB_____

Maiden Name_____Soc.Sec. #_____

Address_____
STREET APT. CITY STATE ZIP

Telephone_____

I authorize East Valley Primary Care Physicians CHECK ONE) TO { }Obtain from: OR { }Release to: `

Facility_____

Address_____
AND STREET APT/LOT # **CITY STATE ZIP**

Telephone_____ Fax_____

I hereby consent to the release of all medical records and other documentation in your possession regarding:

{ } Last 2 Years of Medical Records
{ } Lab Reports, X-Ray Reports
{ } Treatment Related to Specific Injury or Illness_____
{ } Beginning and Ending Dates of Treatment_____

I understand these records may contain information from other health care providers, as well as information, which is administrative in nature. *I specifically consent to the release of any information contained in the medical record, which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.*

I understand that you have no responsibility for the use of distribution of this information by the party to whom it is released. I release you from all liability, which may arise from your compliance with this request to release records.

I authorize you to transmit this information by facsimile transmission (FAX), and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission of my records are transmitted by fax.

_____ _____
Patient/Legal representative signature Date

_____
Witness

If not signed by the patient, list relationship of legal representative here: _____

REDISCLOSURE PROHIBITED: This release, whose confidentiality is protected by state and federal law, prohibits the further release of this information without specific written consent of the patient.

_____ _____
Name Date