

MEDICAL RECORD RELEASE FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize the following Facility/Person to release my Protected Health Information (PHI) by releasing a copy of my medical records to the facility/person listed below.

Facility Name (Please print) _____

(_____) _____ (_____) _____
Phone: Fax:

Patient Name (Please print first/last name)

_____/_____/_____
Date of Birth (MM/DD/YY)

Street Address/City / State / Zip

(_____) _____
Phone Number Email Address

I authorize the following Facility (or person) to receive my Protected Health Information (PHI):

Your Health District, LLC

Laura Magoffie, FNP

2525 W. Carefree Hwy. #118, Phoenix, AZ 85085

Phone: (623)748-9106 Fax: (602)429-8579

INFORMATION TO BE RELEASED (check as applicable):

ENTIRE RECORD excluding the following (CIRCLE as applicable):

-OR-

- | | | |
|---|---|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Treatment Records | <input type="checkbox"/> Care Plan |
| <input type="checkbox"/> Hospital Records & Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other (Specify): _____ |

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above to use or disclose my health information in the manner described above.

SIGNATURE: _____ DATE: _____

Description of Authority to sign if personal/legal representative