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. #124, 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-

□ History & Physical	□ Radiology Reports	□ Progress Notes
□ Allergy Records	□ Treatment Records	□ Care Plan
□ Hospital Records & Reports	□ Medication Records	□ Pathology Reports
□ Lab Reports	□ Operative Reports	□ 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