

East Flagstaff Family Medicine

1515 E. Cedar Ave. #A-3
Flagstaff, AZ 86004
Phone: (928)774-2788
Fax: (928)774-0123

Authorization for Release of Confidential Medical Records

I, _____, Date of Birth ___/___/___

do hereby Authorize:

Doctor's Name: _____
Office/Business Name: _____
Address: _____

to provide East Flagstaff Family Medicine with a complete copy of my confidential medical records.

In addition to the general authorization to release record to the person or entities listed above, I authorize the release of the records described as the following:

- Yes No Communicable disease-related information including record of testing diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases.
- Yes No Drug and alcohol treatment.
- Yes No Psychological/psychiatric information, including diagnosis and treatment.
- Yes No Pathology slides, x-rays, videotapes, photographs.

The reason for these records being sent is:

Please send these records before the following date: ___/___/___

This authorization is valid for six months from the date of signing and may be revoked at any time by providing written notice or revocation. I understand I can not revoke this authorization retroactively for information already released.

(Patient Signature)

Date _____

(Legally Authorized Representative/Relationship to Patient)

Date _____

(Witness)

Date _____