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\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Name Phone Number Date of Birth

\_\_\_\_\_  
Patients Address

I, \_\_\_\_\_ authorize \_\_\_\_\_ (name of provider)

to release

\_\_\_\_\_ my entire medical file, including previous records  
\_\_\_\_\_ records for dates of service \_\_\_\_\_

The above requested records may be released to:

\_\_\_\_\_  
Name of provider/Office

\_\_\_\_\_  
Address

(\_\_\_\_\_)\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_  
Office Number Fax Number

I understand that there is no charge when records are sent directly to a medical provider for continuing care. I also understand that there **IS a charge when records are sent to me or any party other than a medical provider, including lawyers.**

\_\_\_\_\_  
Legally Authorized Representative (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legally Authorized Representative (Signature)

\_\_\_\_\_  
Relationship to patient