Authorization to Release Records

Mesa Family Physicians
2550 E. Guadalupe Rd. #107
Gilbert, AZ 85234
Phone: 480-964-5800 Fax: 480-632-5923

Patient Name:_____ Date of Birth:_____

Address:_____ Social Sec. #:_____

_____ Home Phone #:_____

_____ Work Phone #:_____

Please Choose One Only:

_____ I hereby authorize **MESA FAMILY PHYSICIANS** to **RECEIVE** medical records from the provider listed below.

_____ I hereby authorize **MESA FAMILY PHYSICIANS** to **SEND** medical records to the provider listed below.

PROVIDER'S NAME:_____

FULL ADDRESS:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

For the purpose of:_____

I authorize the release of photocopies of the following medical records in the possession or control of MFP. For the PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL AND HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

This consent will expire sixty (60) days after the signed date below. I may revoke this authorization at any time providing I notify Mesa Family Physicians in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. **I HEREBY RELEASE MESA FAMILY PHYSICIANS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.**

Medical Records (check one)

_____ALL records _____Other (please specify)

Patient Signature:_____ Date:_____

Parent/Guardian Signature_____ Date:_____

Records Prepared by:_____ Date:_____