

Authorization to Release Records

Mesa Family Physicians
1425 S. Greenfield Rd., #101
Mesa, AZ 85206

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.
**** FAX ONLY. WE DO NOT ACCEPT RECORDS IN ELECTRONIC FORMAT. PLEASE MAIL IF MORE THAN 30 PAGES.**

_____ 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: _____