RECORDS RELEASE AUTHORIZATION

Patient Name: _____ **Date of Birth**: _____/_____/_____

I authorize release of my records between:

HEALTH FIRST FAMILY MEDICINE
888 S Greenfield Rd. Ste. 102 Gilbert, AZ 85296
Phone: (480) 507-0700 **Fax**: (480) 507-7477

And the following healthcare provider:

_____
Doctor/Hospital Name

_____
Address/Phone/Fax Number

I am releasing my records: ☐ **TO** Health First Family Medicine ☐ **FROM** Health First Family Medicine

Records I wish to release:

☐ All Records ☐ Lab Reports ☐ Radiology ☐ EKG ☐ Doctor's Notes

Records time frame: From _____ to _____.

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check this box)
☐ For my health care
☐ For payment/insurance
☐ For employment purposes
☐ Other: _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____/_____/_____
Signature of patient/representative **Date**