Regent Physicians of Arizona, PLLC
1590 Paseo San Luis, Sierra Vista, AZ 85635
Phone: (520) 220-5711, Fax: (520) 220-5709

Regent Physicians of Arizona, PLLC
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____ PHONE NUMBER: _____

Regent Physicians of Arizona, PLLC has the authorization of the patient to provide records to, or receive records from the following clinic (s). Choose with clinic you would like the records from or sent to.

Records To / From: **Regent Physicians of Arizona, PLLC** **Phone: 520-220-5711**
1590 Paseo San Luis, Sierra Vista, AZ 85635 **Fax: 520-220-5709**

Method of Delivery: ☐ Mail ☐ Fax ☐ Pick-up

Records To / From:

Name _____

Address _____City _____ State _____ Zip _____

Fax # _____

Reason for Request: _____

MEDICAL RECORDS TO BE RELEASED: _____ ALL RECORDS _____ PROGRESS NOTES _____ LABS _____ X-RAYS _____ HOSPITAL

THIS AUTHORIZATION RELEASES *Regent Physicians of Arizona, PLLC* AND ANY STAFF, EMPLOYEES AND AGENTS OF ANY RESPONSIBILITY FOR INFORMATION CONTAINED IN SUCH RECORDS RELEASED IN CASE OF LOSS OR THEFT FROM MY PERSON, OR DISTRESS ANY TYPE CAUSED TO ME OR OTHER. *Regent Physicians of Arizona, PLLC* WILL NOT BE HELD LIABLE FOR ANY MISUSE OR MISUNDERSTANDING OF THE INFORMATION CONTAINED HEREIN AS A RESULT OF THIS RELEASE.

I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS, INCLUDING ALL HIV AND COMMUNICABLE DISEASE RELATED INFORMATION.

_____ _____
PATIENT SIGNATURE, PARENT OR GUARDIAN DATE SIGNED

_____ _____
SIGNATURE OF WITNESS DATE SIGNED