MARSH FAMILY MEDICINE, PLLC

7440 N. Oracle RD. #7
Tucson, AZ 85704
Phone: 520-797-5603
Medical Records Fax: 520-638-5574

Medical Records Release Form

Authorization to Use/Disclose Healthcare Information

Please Print Clearly and sign the form on the line below. Fax or Mail to the office you want your records from.	**MAIL RECORDS TO:** Marsh Family Medicine, PLLC
Patient Name:	**Address:** 7440 N. Oracle Rd. Building # 7 Tucson, AZ 85704
Date Of Birth:	**Office Phone #:** 520-797-5603 **Office Fax: (medical records only)** 520-638-5574
Phone #:	**New Provider's Name**: Check Correct Box ☐ **Dr.Pat Marsh** ☐ **Dr.Chris Marsh** ☐ **Dr. Julie Morrison**
Last 4 digits of Social Security #:	

By my signature I authorize that my medical records are to be sent from the office of:

Name _____ **Address**_____

Phone: ( ) _____-_____ **Fax**: ( ) _____-_____

The Purpose or Reason for Request: To transfer my medical care to: _____.

I am requesting the following information for the entire time I have been seen at your office and including any consult or transferred medical information from other physicians or caregivers that is in your possession:

1. __√____Treatment records, including progress notes, lab and test results, history & physical reports, procedure reports, and consult reports or pain management contracts.
2. __√____Include outside records. Records from outside your practice.
3. __√____Other specified information including photos, X-Rays, or digital images.
4. __√____Information related to treatment of HIV or AIDS
5. __√____Information related to treatment of mental health issues.
6. __√____Information related to treatment of substance abuse.

Dates of Service to be released: **From**: Past 6 years **to** Date of most recent appointment.

X Signature _____Date_____ POA_____

Relationship if Not the Patient

- Patients Can FAX This Signed Form to their Doctor Instead of Mailing it.

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I understand that if the organization to receive my information is not a health care provider or health care plan; the released information may not be covered by federal privacy regulations. MFM and its providers, administration, and employees are released from any legal liability for disclosure of my protected health information in the extent authorized by this form. I understand MFM will not condition treatment or payment on obtaining this authorization, except where federal law allow such condition.

Medical offices in Arizona are required to provide and forward a copy of your medical records to the doctor of your choice. "When a physician requests a patient's records from another doctor for continuity of care, there is no charge to the Patient" (Arizona State Medical Board Website). Seven to ten business days should be sufficient time to copy and send your records. This Authorization is valid for 120 days from the signature date. It may be revoked by the patient at any time, except for the action that has already been taken on it.