Grand Canyon Family Medicine

3960 E. Riggs Road, Suite 1
Chandler, Arizona 85249
480-786-4441 Fax 480-786-4609

Medical Record Release Form

Patient Name: _____ DOB:_____

YOU MUST FILL OUT ALL AREAS TO OBTAIN OUTSIDE MEDICAL RECORDS
This authorizes you to provide a copy, summary, narrative of my medical records (as indicated by the check mark(s) below) or otherwise release confidential information.

____ Complete Record
____ Records of Care from the following dates: _____ to _____

Please send Records:

(Check one) *T0:* ____ **or** *FR0M*: _____

Facility/Physician Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Fax Number: _____

The reasons/purposes for this release of information are: _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS with the rest of medical records.

Initial: _____ ***Date:*** _____

I understand that you will provide this information 7-10 days from the receipt of request and that a fee for preparing and furnishing information may be charged according to rulings set forth by the Arizona State Board of Medical Examiners.

Patient Signature: _____ **Date:**_____

Witness Signature: _____ **Date:**_____