MIDTOWN
ENDOCRINE ASSOCIATES

Joan F. Bailey, M.D.

2200 N. 3rd Street
Phoenix, AZ 85004
Phone: 602-258-9955 Fax: 602-258-9933

AUTHORIZATION TO RELEASE RECORDS

Patient Name: _____

Address: _____ City: _____

State: _____ Zip:_____ Date of Birth:_____/_____/_____

I the above hereby authorize:

Midtown Endocrine
2200 N. 3rd Street
Phoenix, AZ 85004
Phone: 602-258-9955 Fax: 602-258-9933

Purpose of Release

_____ Appointment / Continuation of Care Other: _____

Medical Records

Specific Records: _____ Date: _____/_____/_____'

Radiology Reports: _____Date: _____/_____/_____

Other: _____ Dare: _____/_____/_____

To release medical record information concerning the above mentioned patient to:

Medical Provider: _____

Address: _____ City: _____

State: _____ Zip:_____

This consent will expire 60 days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify them in writing to that effect. I understand that any release which wasn't made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original and the information released may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

_____ _____/_____/_____
Patient Signature Date

_____ _____
Parent / Legally Authorized Representative Relationship to Patient