

## MEDICAL RECORDS RELEASE

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize \_\_\_\_\_ to disclose protected health information from  
(Name of Doctor or Health Provider)

My medical records to: AllCare Internal Medicine.

I authorize \_\_\_\_\_ to disclose protected health information from  
(Name of Doctor or Health Provider)

My medical records to: AllCare Internal Medicine.

I authorize \_\_\_\_\_ to disclose protected health information from  
(Name of Doctor or Health Provider)

My medical records to: AllCare Internal Medicine.

Specific description of the information to be disclosed. PLEASE CHECK ALL THAT APPLY

- History & Physical
- X-ray/Diagnostic Reports
- Lab Tests
- Other (please specify) \_\_\_\_\_

Specific description of the purpose of the disclosure: PLEASE CHECK ALL THAT APPLY

- Continued Patient Care
- Worker's Compensation
- Insurance Coverage or Payment of Care
- Other (please specify) \_\_\_\_\_

I authorize the provider to use or disclose information related to: PLEASE CHECK ALL THAT APPLY

- AIDS/HIV and other Communicable Diseases
- Genetic Testing Information
- Psychiatric Care Reports
- Alcohol and/or Drug Abuse Treatment

All medical records should be sent to AllCare Internal Medicine, 6401 East Thomas Road, Suite 103, Scottsdale, AZ 85251. Telephone: 480-941-4400 FAX: 480-941-1100

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

I \_\_\_\_\_ act as the legal representative for the following Patient, due to the fact that the Patient is incompetent/lacks the capacity to make decisions for themselves.

\_\_\_\_\_  
Legal Guardian/Representative Signature

\_\_\_\_\_  
Date