DESERET FAMILY MEDICINE

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AUTHORIZATION TO RELEASE RECORDS

Name: _____ Social Security #: _____
Address: _____ Date of birth: _____
_____ Phone #: _____

From: Name and address of facility (doctor or hospital) from which records are to be released:
Name: _____
Address: _____
_____
_____

To: Name and address of facility (doctor or hospital) to which records are to be released:
Name: _____
Address: _____
_____
_____

I authorize the release of copies of the medical records in the possession or control of the above named facility, its employees and/or agents. These medical records may include confidential records such as HIV-related information (as defined in A.R.S. Section 36-661) and/or confidential alcohol or drug abuse related information (as defined in 42 CFR Section 2.1 et seq.) and/or confidential mental health diagnostic and/or treatment information.

Records to be released (check one and specify details if appropriate):

_____ All medical records
_____ Medical records of the last two (2) years of treatment only
_____ Medical records only for the following period: From: _____ To: _____
_____ Records only pertaining to (specify injury or illness): _____

I have read and completed the above or have had the information completed on my behalf freely, voluntarily and without coercion. This authorization is valid for only six (6) months from the date of signature. I may revoke this authorization at any time providing I notify Deseret Family Medicine in writing to that effect. I understand that any release which was made in compliance with this release prior to my revocation of the authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient or guardian signature Date

_____ _____
Print name of patient or guardian Relationship to patient

Staff use only: Prepared by: _____ Date: _____ Sent by: _____ Date: _____

Revised 12/9 mm