AllCare
Primary Care & Walk-ins

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.

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(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

Print Form