AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name:____ Date of Birth: ________________

Address: ____ Home Phone: ________________

____ Other Phone: ________________

Email: ________________

Requesting Records From: ____

____

____

Fax: __________________ Phone: ________________

Mail or Fax Records To:

DeAnna Bullaro-Anderer, DO, FACOOG
Dawn Williams, R.N., OGNP
5304 E. Southern Ave, Ste 110
Mesa, AZ 85206
Fax: 480-237-3049 Phone: 480-237-3040

Please release all medical records unless specific date, procedures, or other items listed below are specified:

Reason for requesting records: ____

Patients – do not mark this box, unless you want a copy of your medical records for yourself, as there is a fee.

I am requesting a copy of medical records for myself. I understand that there will be a $15.00 fee. I also understand that payment is to be made prior to the mailing of or at the time of pickup. I also know that 7 to 10 business days is normal turnaround time for record requests.

I authorize the release of above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug, and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address.

I further authorize that these medical records may be faxed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

____ ____________________
Patient signature (or parent/legal guardian if minor) Date

This fax is personal, confidential and privileged information intended for the named recipient only. If you have received it in error, please destroy it and call us to let us know you received it. Thank you very much.