



Medical Records Release Form

For the patient named below:

First and Last Name	Date of Birth (MM / DD / YYYY)
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A request for a copy of the medical records, as indicated below, **be sent to:**


Please send a copy of the following (check all that apply):

- ☐ Complete Medical Record (including outside providers)
- ☐ Biopsy Report(s)
- ☐ Pathology Slide(s)
- ☐ Lab Report(s)
- ☐ Consultation Report(s)
- ☐ Medication Allergies
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedures
- ☐ Other:

Requested By:	Relation to Patient:
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Signature:	Date:
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Witnessed By:	Date:
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Signature:
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This authorization for medical records release expires 90 days from date of signature.

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20401 N. 73rds Steet Suite 230 Scottsdale, AZ 85255	13995 W. Statler Blvd Suite 150 Surprise, AZ 85374	41810 N. Venture Dr Suite D-136 Anthem, AZ 85086	19646 N. 27 <sup>th</sup> Avenue Suite 305 Phoenix, AZ 85027	9520 W. Palm Lane Suite 115 Phoenix, AZ 85037	2127 E. Baseline Road Suite 104 Tempe, AZ 85283	7331 E Osborn Drive Suite 330 Scottsdale, AZ 85251	1459 S. Higley Road Suite 106 Gilbert, AZ 85296
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