Medical Records Release Authorization

I, ______________________________hereby authorize Dr.______________________________
Patient Physician/Group

____
Doctor/Office Address Phone/Fax

to release the following information on:

Patient Name: ______________________________Birth date:__________________

Patient address: ____

Phone Number: __________________________

Please check all information to be released: (Allow a minimum of 3 business days for copying)

[ ] Entire record set [ ] Problem list [ ] Physician notes
[ ] Medication list [ ] Lab reports [ ] Imaging reports (ultrasound/mammogram)
[ ] Other__________________
[ ] Dates of treatment: ______________thru________________

Information shall be released to:

Elements of Care
Rosemary Fadool, Do
15515 N. Reems Rd. Suite 101
Surprise, AZ 85374
Ph 623-544-1000 Fax 623-544-1025

Purpose for release of records: PLEASE CHECK ONE

[ ] 2nd Opinion/consult	[ ] Moving	[ ] Changing physicians
[ ] For attorney	[ ] physician moved	[ ] Other__________

Fees:

I understand that a copying fee of $25.00 will be charged for records that are directly released to the patient.
We do not charge for physician to physician transfers of medical records.

Authorized signature: ______________________________**Date:**__________________

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I authorize the following individuals to pick up my records: ______________________(must bring picture ID)
Relationship to patient: ______________________________________
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