

Dr. Green Clinic Clinic: 602-500-8400 Fax: 602-325-0107	4245 W. Thomas Rd., Ste 100 Phoenix, Arizona 85019	5210 S. Priest Dr., Ste 5 Tempe, Arizona 85283	330 E. Southern Ave., Ste 28 Mesa, Arizona 85210
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MEDICAL RECORDS RELEASE AUTHORIZATION

PLEASE PRINT

Today's Date: _____

Patient Legal Name _____

First

Middle Initial

Last

Date of Birth _____

Address (Street) _____

(City, State, Zip) _____

Mobile Phone _____

Home Phone _____

To: (Name of your Doctor or Facility) _____

Address (Street) _____

(City, State, Zip) _____

Phone _____

Fax number _____

Place a checkmark beside each type of record you are requesting:

✓	Last 2-3 progress notes, to include intake notes, diagnoses, treatments & medications
	Laboratory reports for previous 12 months
	Imaging/ radiology reports (please do not send films) for previous 12 months
	Biopsy/ surgery reports for previous 12 months
	Other:

Records released for the purpose of: Concurrent Care Other _____

Please **FAX** the authorized records and information to: **602-325-0107**

I authorize release of the requested medical records to Dr. Green Clinic. I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

I have read the above and authorize the disclosure of the protected health information.

Patient Signature _____