

TAYLOR HEALTH

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Taylor Health | 14415 N 73rd St., Ste 105 Scottsdale, AZ 85260
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RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Taylor Health does not offer reimbursement for records received.

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City: _____ State: _____

Zip Code: _____ Patient Phone: _____

Name of Practice and Physician: _____

Practice Address: _____ City: _____ State: _____

Zip Code: _____

Practice Phone: _____ Practice Fax: _____

Please Release the following Information

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/ clinic/ hospital to provide the following information via telephone consultation:

- _____ All Medical Records Necessary for the Continuity of Care from within the past 12 months
_____ If there are no records within the last 12 months, please send the most recent on file
_____ Laboratory and Diagnostic Imaging Reports

I understand that this authorization will expire within 180 days from the date of this request unless I otherwise specify. I request that this authorization be in effect until _____
(180 days unless otherwise specified)

Patient Signature: _____ Date: _____

Parent/ Guardian (if applicable) Signature: _____ Date: _____

I understand that certain information in records cannot be released without specific authorization because of federal or state laws. By signing below, I specifically authorize release of the following confidential information to Taylor Health. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation

- _____ HIV/AIDS test results and related information, including high risk behavior documentation
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Mental Health information

Federal Regulation 42 CFR Part 2 requires a description of how much and what kind of above information is to be disclosed. Please provide a description of this information: _____

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