Medical Records Release

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Name _____

Address _____

Street City State ZIP

Home phone _____ **Work phone** _____

Cell phone_____ **Email**_____

Date of birth _____

Please transfer my medical records* as follows:

TO or FROM (please circle)

TO or FROM

_____

_____

_____

_____

Modern Family Medicine
7522 E. 1st Street
Scottsdale, AZ 85251
P: 602-363-1631 Fax: 888-360-8644

***Records to be released**:

__ Annual exam and Pap smear / Prostate
__ Labs/Xray
__ Birth control
__ Abortion care
__ All medical records
__ Other _____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____
Signature

_____
Witness

_____
Interpreter, if necessary

_____
Date