

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 _____

Home phone _____ Cell phone _____

Email _____ Date of birth _____

Please transfer my medical records* as follows:

TO or FROM (please circle)

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

TO or FROM (please circle)

***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