

PATIENT REQUEST FOR RELEASE OF MEDICAL INFORMATION

SECTION I: PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #
Phone #	

SECTION II: REQUEST FOR SPECIFIC ITEMS TO BE RELEASED

I request Arizona Perinatal Care Centers to release the medical information identified below relating to my treatment during these dates: from _____ to _____			
<input type="checkbox"/> Cardiovascular Reports	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Note	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Complete Medical Record (will not be faxed)
<input type="checkbox"/> Photographs, videotapes or other digital images	<input type="checkbox"/> Records of Prescription Medications		
<input type="checkbox"/> Other (describe):			

SECTION III: DELIVERY METHOD

<input type="checkbox"/> Hold record for pick-up, I personally will claim the record	<input type="checkbox"/> Fax to this number: <i>(NOTE: Complete medical record will not be faxed)</i>
<input type="checkbox"/> Hold for pick-up by my authorized representative: Name: _____ <i>(NOTE: Your authorized representative will be asked to produce proof of positive identification)</i>	<input type="checkbox"/> Mail to this address:

SECTION IV: DUPLICATING FEES

I understand:

(1) There is no charge associated with having my records sent directly to another physician or provider to facilitate the continuity or transfer of my care.

(2) This request may take up to ten days to satisfy. _____ (initial)

SECTION V: RELEASE

I hereby release Arizona Perinatal Care Centers and its employees from any and all liability that may arise from the release of information as I have directed.

Signature of Patient or Legal Guardian

Date