Harmony MEDICAL CARE

81 W Guadalupe Road, Ste 111
Gilbert, AZ 85233
Phone: 480-366-4490
Fax: 480-854-3618

Authorization for Release of Medical Records

Patient Name: _____ DOB ____/____/_____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Email Address: _____

Please fax records to Harmony Medical Care: 480-854-3618 – or by mail to the address above.

Requesting Records From:

Office/ Physician: _____

Phone: _____ Fax #: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Please release all medical records unless a specific date, procedure or other items are listed below:

_____

Reason for requesting records: _____

I authorize the release of the above requested records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address.

I further authorize that these medical records be faxed or mailed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

Signature: _____ Date: _____

Relationship: _____