MRN :_____

Midwestern University Multispecialty Clinic
19389 N 59th Avenue
Glendale, Arizona 85308
Medical Records (623) 537-6066 Fax (623) 537-6014

Doctor: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS-ONE TIME USE

Patient Name: _____ Date of Birth:_____

Phone: _____ Purpose: ☐ Treatment ☐ Personal ☐ Billing ☐ Other: _____

Information to be released:

_____ All Records _____ Labs Reports _____ Xray Reports _____ Other : _____

_____**Alcohol and Drug Abuse Treatment.** My medical record contains information regarding alcohol or drug treatment that is protected by federal law, I authorize the disclosure of such information or record.

_____**HIV/AIDS Information.** My medical record contains information regarding my HIV/AIDS status, treatment, or testing, I authorize disclosure of such information.

_____**Behavioral Health Notes/Records. If checked,** I authorize the disclosure of any behavioral health notes or information in my medical record.

INCOMING MEDICAL RECORDS

I authorize (previous doctor or clinic) _____
to send /release photocopies of my medical records to **MIDWESTERN UNIVERSITY MULTISPECIALTY CLINIC.**

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OUTGOING MEDICAL RECORDS

I authorize ***MIDWESTERN UNIVERSITY MULTISPECIALTY CLINIC*** to send /release photocopies of my medical records

to _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

I understand I may withdraw my authorization by submitting a written request to Midwestern University Multispecialty Clinic. I understand any revocation is not effective to the extent action has already been taken in reliance on this authorization. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law. This authorization is not intended to affect a patient's ability to receive medical care.

_____ _____
Patient Signature/Legal Representative Witness Signature

_____ _____
Patient Printed Name Date Printed Name of Witness Date

07/25/13