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### **AUTHORIZATION FOR RELEASE OF RECORDS**

The purpose of this form is to authorize release of medical records from another physician/medical provider's office, medical facility or laboratory to Desert Family Medical Center for the following patient listed below:

Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I understand that the information in my medical health record may include information relating to sexually transmitted diseases, AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). It may also include information about treatment for alcohol and drug abuse, and/or mental or behavioral health services.*

Please release the following records (Check all that apply):

Medical History  X-Ray Reports  Surgical Reports  Lab Reports  Other

Dates of Service: From \_\_\_\_\_ To \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Records to be released to Desert Family Medical Center from the following physician/medical provider's office, medical facility or laboratory is listed below:

Name of Medical Office/Facility/Lab: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please send patient records via (Check choice of delivery):  US Mail  Fax

Mailing address and fax number to Desert Family Medical Center is listed at the top of this page.

This authorization form will expire 90 days from the date signed by the patient on this form.

Revised 11/1/10