Internal Medicine Physicians Associates, P.C.
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1515 N. 9th Street, Ste. A
Phoenix, AZ 85006

Medical Records Request and Authorization to Release Health Care Information

Patient name: _____Date of Birth: _____
Previous name: _____Social Sec. #: _____

I request and authorize my prior physician and their office staff to release the health care information of the patient named above **TO/FROM**:

Internal Medicine Physicians Associates, P.C. Phone: (602) 258-5545
1515 N. 9th Street, Ste. A **Fax: (602) 252-6115**
Phoenix, AZ 85006

T0/FROM ***PLEASE SEND THIS FORM BACK WITH THE RECORDS***

Doctor/Hospital Information:

Name: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

This request and authorization applies to (check any that apply):

____Consult Notes (2 yr)	____Progress Notes (2 yr)	____Vaccine Record (entire)
____Discharge Summary	____EKG's (2 yr)	____Colonoscopy (last 1)
____Xrays/CTs/MRIs (2 yr)	____Dexa/Mammo/Pap (3 yr)	____Labs (2 yr)
____Stress Test (last 1)	____Echocardiogram (last 1)	____ All Recent Hospitalization

____Other _____

The purpose of this release is for my treatment/continued care. I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time if requested in writing to: Internal Medicine Physicians Associates, P.C., 1515 N. 9th Street, Ste. A, Phoenix, AZ 85006. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This consent will terminate in one year unless the person or organization to whom disclosure is authorized is a treating healthcare provider.

Of note to our patients, while we review medical records we receive from outside sources to the best of our ability and we incorporate the most pertinent information into our electronic records, not all of the medical records from other offices will be maintained by our office. Any records that you have or want for yourself should be copied and kept in your personal files.

Patient Signature: _____ Date: _____Patient

Representative Signature: _____