tatum highlands medical associates

Dr. Peter Levins, MD **Paul Strauss, PA-C** **Nicole Fields, FNP** **Cari Montoya, FNP**

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____

The above named patient is authorizing the release of their medical records and personal health information.

I authorize the release of my medical records, please SEND my records TO:

_____ **Tatum Highlands Medical Associates**

26224 N Tatum Blvd., Suite 15A
Phoenix, Arizona 85050
Phone 480-663-9632
Fax 480-419-6782

_____ **Other Facility (address below)**

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Reason for request: _____

I authorize the release of my medical records, my records will be sent FROM:

_____ **Tatum Highlands Medical Associates**

26224 N Tatum Blvd., Suite 15A
Phoenix, Arizona 85050
Phone 480-663-9632
Fax 480-419-6782

_____ **Other Facility (address below)**

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

I authorize you to send the following (check all that apply):

_____Complete Medical Records _____Progress Notes

_____Lab/Pathology Reports _____Immunization Records

_____Cardiology/EKG Reports _____Imaging Reports

By signing below, I understand that authorizing the release of medical records and personal health information is voluntary and therefore I release Tatum Highlands Medical Associates, their providers, and their employees from any and all liabilities, damages, and claims which may arise from the release of information. In addition, I understand that disclosure of this information may not be protected by federal confidentiality rules.

I also understand that information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), and information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This authorization may be revoked at any time, however the revocation must be submitted in writing to Tatum Highlands Medical Associates and does not apply to health information which has already been released.

Patient Signature: _____ **Date:**_____