



Dr. Peter Levins, MD Nicole Fields, FNP Cari Montoya, FNP Ashley Hatch, 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

_____ Other Facility (address below)

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

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

_____ Other Facility (address below)

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

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: _____