

Friedman Plastics
7545 E. Angus Drive
Scottsdale, AZ 85251
Phone: 480.664.0125 Fax: 480.664.0219

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

_____ I authorize the release of my medical records FROM:

Physician/Facility: _____ Phone: _____

Address: _____ Fax: _____

_____ Please send my medical records TO:

Physician/Facility: _____ Phone: _____

Address: _____ Fax: _____

Reason for the release of information:

_____ Insurance _____ Transfer of Care _____ Personal Use _____ Legal
_____ Moving Out of Area _____ Specialist Consult/Second Opinion _____ Other: _____

Please provide the following records (check all that apply):

_____ Complete Medical Record _____ Treatment Notes _____ History & Physical
_____ Consultation _____ Radiology Reports _____ Photographs
_____ Laboratory Reports _____ Operative Reports _____ Other: _____

I do _____ I do not _____ authorize the facsimile/email transmittal of health information.

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

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Friedman Plastics. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire automatically six (6) months from the date on which it was signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient or Legal Representative Signature

Date

Witness Signature

Date