Arizona Bleeding Disorders Health & Wellness Center
My Neighborhood Primary Care
821 N. 5th Ave Phoenix, AZ 85003
(P) 602-680-7722 (F) 602-682-5415

Medical Records Release Form

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Patient Address: _____
City State Zip Code

I authorize Arizona Bleeding Disorders Health & Wellness Center & My Neighborhood Primary Care to release my Medical Records to:

_____ at _____
(Name of clinic, individual, etc.) (Fax Number)

☐ Send all records **excluding** the following:

☐ Treatment of Alcohol and/or Drug Abuse ☐ Sexually Transmitted Disease ☐ HIV/AIDS

☐ Developmental/Behavioral Health Care/Psychiatric Care

OR

☐ For the following date(s) of service:

From (MM/DD/YYYY): _____ / _____ / _____ To (MM/DD/YYYY): _____ / _____ / _____

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

I understand that I have a right to receive a copy of this authorization upon my request.
Copy requested: ❑ Yes ❑ No

Patient's Signature: _____ Date: _____

or Personal Representative: _____