



**PO Box 7904  
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**Office Hours:  
Mon-Thurs: 9am-4pm (closed 12pm-1pm)  
Fri: 9am-12pm**

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**www.doctorcareaz.com**

## Medical Records Release Form

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Ph \_\_\_\_\_ Cell \_\_\_\_\_

### Records Release Authorization

By my signature, I authorize **DoctorCare** to receive my pertinent medical records for the patient identified by the information listed above.

### Medical Records Requested

For the past 18 months:

**\*\*Radiology (Xray, Ultrasound, CAT Scan, MRI, Special tests) Reports, EKG, Specialist Consults, Hospitalization Summaries, Labs, Updated Medication List.\*\***

I authorize the release of photocopies of the following medical records to DoctorCare, its employees, and/or agents. For the purpose hereof, "Medical Records" includes the following:

- Confidential HIV and communicable disease-related information (A.R.S. Section 36-661)
- Confidential Alcohol & Drug Abuse-related information (42 CFR Section 2.1 ET SEQ)
- Confidential Mental Health Diagnosis/Treatment Information
- Confidential Genetic Testing Information (A.R.S. Section 12-2801)

I have given my consent freely and without coercion. I may revoke this consent at any time by notifying DoctorCare in writing. A photocopy or Facsimile of this authorization can substitute for the original.

MAIL RECORDS TO: PO Box Listed at top of consent form

\_\_\_\_\_  
**Patient/Authorized Signature**

\_\_\_\_\_  
**Date**