MDS Family Practice

10769 Frank Lloyd Wright Blvd. Suite A 120, Scottsdale, AZ 85259

P: 480-848-0991 F: 480-452-0929 www.mdsfamilypractice.com

Medical Records Release Authorization

I authorize and request MDS Family Practice to receive medical records from your office.

Physician and/or Practice name:_____

Phone: _____ Fax: _____***Fax number is required**

****** Please fax last year only including most recent office notes, labs and imaging available ******

Please check one of the following:

☐ I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

OR

☐ I do not give permission to release information regarding the diagnosis or treatment of HIV/AIDS, or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

Name: _____

DOB: _____

Phone: _____

Signature: _____ Date: _____

I certify this request has been made voluntarily and that the information provided is accurate to the best of my knowledge. I understand I may revoke this authorization at any time, except to the extent that action has already taken to comply with the request. A copy or facsimile of this authorization with my signature may be used with the same effectiveness as an original.