



RECORD REQUEST

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

INFORMATION TO BE RELEASED:

- 1 Year of Records ONLY
- Last Mammogram, Dexa, Colonoscopy
- Last OV note, Labs, Imaging
- Other

**WE DO NOT ACCEPT RECORDS ON CDS**

I authorize the release and disclosure of the above information as follows:

RECEIVING FROM:

PLEASE SEND RECORDS TO:

Doctor/Facility: \_\_\_\_\_

Doctor/Facility: GRAND MEDICAL ASSOCIATES

Address: \_\_\_\_\_

Address: 14674 W MOUNTAIN VIEW BLVD #200

\_\_\_\_\_

SURPRISE, AZ. 85374

Phone: \_\_\_\_\_

Phone: 623-544-6860

Fax: \_\_\_\_\_

Fax: 623-544-6861

**\*\*\*YOU MUST PROVIDE A FAX NUMBER SO THAT WE MAY REQUEST YOUR RECORDS\*\*\***

This authorization shall expire 180 days from the date below unless otherwise specified here: \_\_\_\_\_. I understand I may withdraw my authorization at any time by submitting a written request to Grand Medical Associates. I understand any revocation is not effective to the extent action has already been taken in reliance on this authorization. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law. This authorization is not intended to affect a patient's ability to receive medical care.

Alcohol and Drug Abuse Treatment, if checked above, to the extent my medical record contains information regarding alcohol or drug treatment that is protected by federal law. I authorize the disclosure of such information or record.

HIV/AIDS Information, if checked above, to the extent my medical record contains information regarding my HIV/AIDS status, treatment, or testing, I authorize disclosure of such information.

Mental Health Information, if checked above, to the extent my medical record contains information regarding Mental Health status, treatment, or testing. I authorize disclosure of such information.

\_\_\_\_\_  
Signature of Patient of Legal Representative      Date