



18555 N. 79th Ave, B-108
Glendale, AZ 85308

Authorization/Request for Medical Records
Office 623-773-2828 Fax 623-773-0370

"This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is NOT sufficient for this purpose."

Patient Information:

Patient's Name: _____ DOB: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____

Requested Records From:

Dr Banister Dr McDonald
 Ron Raybon, PA
18555 N 79th Avenue Suite B-108
Glendale, AZ 85308
Tel 623-773-2848
Fax: 623-773-0370

Records Released To:

Name: _____
Address: _____
Phone: _____
Fax: _____

Reason for Request:

- Changing of Physician
- Insurance Request
- Moving out of Geographical Area
- Specialist Request for Treatment
- Parent/Legal Guardian's Copy
- Other: _____

Records to be included:

- Past 2 years of notes, labs, radiology, immunizations*
- All Records *
- Immunization Records
- Progress Notes
- Lab Reports
- Radiology Reports
- Other: _____

*All records to be disclosed will include communicable disease information, e.g. AIDS information or others. This information gives consent to inspect and copy medical records whose confidentiality is protected by Federal laws which include special authorization to release medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and the comprehensive alcohol abuse and alcoholic prevention, treatment and rehabilitation act amendments of 1974 (9.L. 93-282). The undersigned hereby authorizes and consents to the disclosure by the above named clinic to the above named company or persons, or their representatives, or the bearer of this instrument of any and all information, records, documents, reports, clinical abstracts, histories, and charts, of every kind and description relating to my condition, care, confinement and treatment, and consent to the furnishing them of photo static copies or other copies of same. BE IT FURTHER KNOWN that this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. *If this release is not a physician request, a charge for the records will apply.*

I, _____ (patient, parent or legal guardian), am authorizing release of medical records as specified.
This request is in effect until _____ (date of expiration).

Signature: _____ Date: _____

t: 623.773.2848 f: 623.773.0370