



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 (42DFR 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:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Records Released To:**

Dr. Banister  Dr. Lampert  Dr McDonald  
18555 N 79<sup>th</sup> Avenue Suite B-108  
Glendale, AZ 85308  
Tel 623-773-2848  
Fax: 623-773-0370

**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\*
- \_\_\_ 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: \_\_\_\_\_**