Medical Records Release

Patient Name: ____ DOB: ___/___/____

I authorize (doctor or hospital name):____

Address: ____

City: ____________________________ State: ___________ ZIP: ______________

Phone (_____) ______________________ Fax (_____) _______________________

To release information from my medical records to**:**

Dr. Alan Hamilton
5425 East Bell Road, Suite 145
Scottsdale, AZ 85254
602-354-3172 FAX: 602-354-3173

Please release: All records _____

OR from ___/___/____ to ___/___/_____

The undersigned authorizes the release of records pertaining to:

1. Testing and/or treatment for AIDS and AIDS related diseases Yes__ No __
2. Treatment for psychiatric illness Yes__ No __
3. Treatment for drug and/or alcohol abuse Yes__ No __

This authorization shall be valid for a period of 90 days (unless revoked earlier**).**

I hereby waive all provisions of law and privilege relating to the disclosures hereby authorized.

Signature of patient/guardian: _________________________ Date: ___/___/_____

Address: ____

City: ___________________________ State: ___________________ ZIP: _________

Phone: _______________________

Name and relationship if other than self: ___________________________________

Office use only: Date received: _____________Date sent: ________________ By: __________