enticare.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO OR FROM ENTICARE PC

3420 SOUTH MERCY ROAD,
SUITE 107
GILBERT, AZ 85297
T(480)214 9000
F (480)214 9999

1968 NORTH PEART ROAD,
SUITE 20
CASA GRANDE, AZ 85122
T(520)509 1302
F (520)509 1417

2051 WEST CHANDLER BLVD,
SUITE 5
CHANDLER, AZ 85224
T(480)214 9000
F(480)889 1859

REQUESTOR:
PATIENT NAME: ______________________________ **D.O.B:** _____________
ADDRESS: ____
DAY PHONE: ______________________ **EVE. PHONE:** __________________
SOCIAL SECURITY NUMBER________-________-_________

RECIPIENT:
NAME: ____
ADDRESS: ____
PHONE #: ___________________________ **FAX #:**________________________
REASON FOR RECORDS:____
____
____

I hereby authorize the release of photocopies of medical records concerning the above-named patient. To release photocopies of the following medical records and/or x-ray films in the possession or control of its employees and/or agents. FOR THE PURPOSES HEREOF,"MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED I 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

MEDICAL RECORDS (CHECK ALL REQUESTED):

◊ **All medical records of the past 2 years or treatment**
◊ **CT's, MRI'S, or Radiology**
◊ **Audiology or Sleep Studies**
◊ **The following described records only: (specify types and dates)**
◊ **Specific area:**____**Dates:**_____________________________
◊ **Other**____
____**Dates:**_____________________________

This consent will expire in sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify in writing to that effect. I under-stand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentially. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

____ __________________________________
Patient Signature or Parent/Legally Authorized Representative **Date**