Foothills Internal Medicine

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Medical Records Release

I, ____________________________, request my medical records including current and previous records, which are part of my medical background be released to ***Foothills Internal Medicine*.**

Persons Authorized to Disclose Information

(WHERE RECORDS ARE COMING FROM)

Provider's name: ____

Facility: ____

Address: ____

Telephone: ____________________ **Fax:** ____________________

Patient Authorizing Release

Patients Name:____

Social Security Number: ________________**DOB:** ______________

Other Names Used In The Past: ______________________________

This authorization is effective for one year unless revoked or terminated by the patient.

Patient Signature: ____