Chandler Primary Care

AUTHORIZATION TO RELEASE RECORDS

Patient Name:_____ Date of Birth:_____

Address:_____

Phone Number: H/C - _____ Email-_____

I hereby authorize: Chandler Primary Care
5950 S Cooper Rd
Chandler, AZ 85249
Phone: 480-895-3777
Fax: 480-895-3731

Purpose of Release –My personal records.

Medical Records
☐ labs/radiology records dated_____
☐ Copy of medical records of the last 2 years of treatment.

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. This consent expires 90 days after the signed date below. I may revoke this authorization at any time providing I notify_____ in writing to that effect. I understand that any releases which were made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient/Legal Representative Signature Date