East Flagstaff Family Medicine
1515 E. Cedar Ave. #A-3
Flagstaff, AZ 86004
Phone: (928) 774-2788
Fax: (928) 774-0123

Authorization for Release of Confidential Medical Records

I, _____, Date of Birth _____

Authorize_____
_____
_____

to provide East Flagstaff Family Medicine with a complete copy of my confidential medical records.

I, _____, authorize East Flagstaff Family Medicine to provide

Date of Birth _____

a complete copy of my confidential medical records to:

_____
_____
_____

In addition to the general authorization to release record to the person or entities listed above, I authorize the release of the records described as the following:

Yes	No	Communicable disease-related information including record of testing diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases.
Yes	No	Drug and alcohol treatment.
Yes	No	Psychological/psychiatric information, including diagnosis and treatment.
Yes	No	Pathology slides, x-rays, videotapes, photographs.

Disclosure of the information is requested for the purpose of:

_____

_____

This authorization is valid for six months from the date of signing and may be revoked at any time by providing written notice or revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ Date_____
(Patient Signature)

_____ Date_____
(Legally Authorized Representative/Relationship to Patient)

_____ Date_____
(Witness)