Gilbert Center
For Family Medicine

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Phone: *480-539-8680* **Fax:** *480-539-1763*
WWW.GILBERTCENTER.NET

MEDICAL RECORDS REQUEST/ RELEASE

_____ _____/_____/_____
Patient Full Name **Birth Date**

_____ _____-_____-_____
Address **Social Security Number**

PURPOSE OF DISCLOSURE:

☐ Continuation of care ☐ Transfer care ☐Other: _____

AUTHORIZATION:

☐ I authorize the release of my medical records **from another provider/facility to Gilbert Center for Family Medicine.** (Provider/Facility → GCFM)

☐ I authorize the release of my medical records **from Gilbert Center for Family Medicine to another provider/facility.** (GCFM → Provider/Facility)

Provider /Facility Information: OUTSIDE OF GCFM

_____ (_____)_____-_____
Provider/ Facility Name **Phone**

_____ (_____)_____-_____
Address **Fax**

RECORDS TO BE RELEASED:

☐ All medical records are authorized to be released.

☐ Other medical records authorized to be released: _____

FROM: _____ TO:_____

The following record types are protected by Arizona and federal law and require your separate, affirmative consent before they may be released. Please initial each category you wish to include. Categories left blank will be excluded from this release.

Initials	Record Category	Legal Authority
	HIV test results and related information	*A.R.S. § 36-664*
	Mental health and behavioral health treatment records	*A.R.S. § 36-509*
	Alcohol and substance use disorder treatment records	*42 CFR Part 2*

Consent: This consent will expire sixty (60) days after the signed date below. I may revoke this authorization at any time providing I notify Gilbert Center for Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original**. I hereby release Gilbert Center for Family Medicine from all legal responsibility or liability that may arise from the act I have authorized above.**

_____ _____/_____/_____
Patient Name (If Minor: Parent / Legal Guardian) **Date**

_____ _____/_____/_____
Patient Signature (If Minor: Parent / Legal Guardian) **Date**