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MEDICAL RECORDS RELEASE FORM

Patient Information (please print):

Name: _____ DOB: _____

Address: _____

REQUEST records from the following:

RELEASE STAA records to the following:

Entity: _____
(Name of person or organization)

Phone number: _____ Fax: _____

Email: _____ Address: _____

City: _____ State: _____ Zip code: _____

- Visit Notes
- Lab Results
- Imaging and Diagnostic Reports
- Sleep Study Report
- Injection Record
- Serum Recipe (Extract Formula)
- Skin Test Results
- All Office Records
- Pulmonary Function Tests
- Pathology Reports
- Biopsy Results
- Outside Medical Records

Other: _____

Preferred method of transmission (circle one): Fax / Mail / Email

I hereby authorize San Tan Allergy and Asthma to release or obtain medical records from the period _____ to _____. I understand that this authorization covers all records, including those related to communicable diseases, AIDS, HIV, behavioral and/or mental health care (excluding psychotherapy notes), substance abuse and/or addiction treatment, and genetic testing, if any such records exist. I understand that this authorization will expire 12 months after the date of signing unless an earlier date is specified here: _____. I understand that I may be charged a reasonable fee in accordance with state law.

Signature: _____ Date: _____
Parent or guardian signature: (if patient is under 18)

*****PRIVACY NOTICE*****

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