First Choice Medical Center
3769 Crossings Dr. Suite B
Prescott, AZ 86305
Phone: 928.888.9750
Fax: 928.888.9790

Medical Record Release Authorization

Patient Name_____Maiden Name__SS#_____ Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address: _____ _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

B) To be released TO:

Name First Choice Medical Center

Address 3769 Crossings Dr. Suite B

City/State/Zip Prescott, AZ 86305

Phone# 928-888-9750 FAX# 928-888-9790

C) For the purpose of:

_____

D) Records Format: Records should always be deliveredvia secure fax or postal services.

☐ **Please do not send records on a CD**

Date Range_____to_____

☐ Physicians Office Notes ☐ Cardiology/EKG Reports
☐ Immunizations ☐ Lab/Path Reports
☐ Operative/Procedure Reports ☐ Radiology/XRay/MRI Reports
☐ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ ****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

***PLEASE READ** Fee Information: FCMC reserves the right to charge the fee schedule as set by the State of Arizona. A $20.00 handling fee, $0.50 per page and postage may be invoiced to you from FCMC with all of thenecessary directions to receive your records. By signing this authorization, you are agreeing to pay FCMC for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as acourtesy.