



Gilbert Center For Family Medicine

652 East Warner Road, Suite 107, Gilbert, AZ 85296
Phone (480)539-8680 Fax (480)539-1763

Records Request

Patient Name

____/____/_____
Birth Date

Address

____-____-_____
Social Security Number

Authorization

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

Records To Be Released

Medical records shall include all confidential aids, communicable disease, HIV related information, confidential alcohol or drug abuse related information, and confidential mental health diagnosis/treatment information. Release the following described medical records only (specify types and dates).

- All medical records authorized to be released.
- Other medical records authorized to be released: _____

Provider /Facility Information

_____ Provider/ Facility Name		(____)____-____ Phone
_____ Address		(____)____-____ Fax

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