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

Records Request/Release

_____ _____/_____/_____
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)

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

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 are 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**