Request to Obtain Access to medical Records Transfer Form

Authorization: Your Information

Last Name:	First Name & MI:	DOB
Other Last names used:	Year last seen:	
Address:	Apt #:	
City:	State:	Zip:

☐ **Obtain a copy of my records ($75.00 fee)** ☐ **Transfer my records to Grayhawk Family Practice**
☐ **Transfer my records to another provider**

Name of Provider:	
Address:	10051 E Dynamite Blvd Ste 110
City	Scottsdale Az 85262
State Zip	Phone: 480-473-7003 Fax: 480-473-4499
Phone: Fax:	Email: Nikki.King@grayhawkfamilypractice.com

Purpose of Disclosure: (Please check one)

☐ Individual request ☐ Legal ☐ Insurance ☐ Care with new provider

This Authorization applies to: (Please check at least one option)

☐ All records retained by provider

☐ The types of records indicated below between the following dates of service: from _____ to _____

☐ Progress notes ☐ Lab reports ☐ Immunization records ☐ Hospital records ☐ Imaging reports

☐ Other specified information: _____

Disclosure of sensitive information

I understand that my health record may contain sensitive information relating to my condition(s). This includes, but is not limited to information relating to HIV or confirmed diagnosis of or treatment for any other sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.

☐ By checking this box, I choose to exclude the above types of information from this disclosure.

Terms and Conditions

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Officer at Grayhawk Family Practice and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that has already been disclosed. To contact the Privacy Officer, please call 480-473-7003 or email info@grayhawkfamilypractice.com
- I may refuse to sign this Authorization. My refusal will not effect my ability to obtain treatment or payment or eligibility for benefits.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- I may be responsible for the cost of copying my medical records under state law.
- This Authorization expires one (1) year after the date of signature unless otherwise specified:

_____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patients Name | Print legal guardians name (if applicable)