12361 W. Bola Dr. #109
Surprise, AZ 85378
Ph: 623.227.1000 Fax: 623.227.2000

MEDICAL RECORDS RELEASE FORM

Date: ____ / ____ / _____

Patient name: _____Date of Birth: _____

Address: _____

Phone: _____Email#:_____

I authorize:

Physician Name: _____

Address: _____

Phone: _____Fax: _____

To release information to: **MORE MD**

PLEASE DO NOT SEND RECORDS ON A CD. RELEASE ONLY:

o Last 3 office notes
o Recent labs
o Last EKG
o Last EMG
o Last colonoscopy
o Last echo/dopplers
o Patient x-rays/imaging
o All Records

I understand that medical information may include, if applicable, alcohol and/or drug abuse and/or mental health treatment information protected under the regulation in Title 42 of Code of Federal Regulations Part II. Information about Human Immunodeficiency Virus (HIV), acquired immunodeficiency syndrome (AIDS and AIDS related complex), as defined by the Department of Public Health rules (1989 Public Act 174), third party information. I understand that I may revoke this authorization at any time by notifying MORE MD in writing, otherwise, it will remain in effect for a period of 12 months from the date signed. This authorization pertains to the fulfillment of the above stated purpose(s). Covered entity will not condition treatment, payment, enrollment, or eligibility. I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA's privacy rule protections.

I have read the above statement and I acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient, Parent, or Guardian Signature: _____