Medical Records Release/Transfer

I, Patient Name: _____ DOB: _____
Phone: _____ Other: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Authorize:
MALIN MEDICAL
17301 E Spring Valley Lane, Suite F,
Spring Valley, AZ 86333
P: (928) 632-4909 F (928) 632-4973

To **RELEASE** / **RECEIVE** the information as described below:
(Circle One)

Provider Name/Hospital: _____

Address: _____

Phone: _____ Fax: _____

Notice to recipient: This information has been disclosed to you from records that Federal Law protects. These records are not subject to redisclosure. Federal Regulations prohibit you from making further disclosure of **Substance Abuse** information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Reports Requested:

- ☐ Clinical Visit Notes
- ☐ Verbal Disclosure of Treatment information
- ☐ Substance Abuse Information
- ☐ HIV/AIDS Information
- ☐ Test Results/Labs, Dates: _____
- ☐ Discharge Summary
- ☐ Treatment/SVC Plan
- ☐ Medications
- ☐ Psychiatric Evaluation

Date of Service (for records to be sent):

- ☐ Past 60 Days
- ☐ Past 90 Days
- ☐ Past 6 Months
- ☐ Past 12 Months
- ☐ Other: _____

Purpose for Request: _____

I understand that I do not have to sign this authorization in order to obtain health care benefits, only that by not signing, my records cannot be transferred. I understand that I may revoke this authorization in writing at any point in time. However, once the office has disclosed health information to the intended party; the person or organization that received it may re-disclose it as a privacy laws may no longer apply to protect it.

_____ _____
Patient/Guardian Signature Date

_____
Other Required Signature (if applicable)