# Medical Record Release / Transfer

Patient Name: _____ DOB: _____

Mailing Address: _____ Phone: _____

City, State & Zip: _____

**Authorizes:**

Malin Medical
1780 N. Hwy 89
Chino Valley, AZ 86323
Phone: 928-460-5214 Fax: 928-441-2915

To **RELEASE / RECEIVE** the information as described below:
*(circle one)*

Provider Name/Hospital: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ *(required)*

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 mical or other information is not sufficient for the purpose.

**Reports Requested:**

- ☐ Clinical visit notes ☐ Discharge summary
- ☐ Test results: _____
- ☐ Lab results. Dates: _____
- ☐ Other: _____

**Dates 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 don not have to sign this authorization in order to obtain health care benefits, only that by not signing, my records can not 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 privacy laws may no longer apply to protect it.

_____ _____

Patient/Guardian Signature Date