

RECORDS RELEASE AUTHORIZATION

TO: _____
(Doctor/Hospital/Facility)

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Dr. Anne Marie Palzer
1220 N. Spencer Ste. 200
Mesa, AZ 85203
Ph: 602.326.7001
Fax: 480.474.8253

UNLESS OTHERWISE INTRUCTED, PLEASE FAX ALL RECORDS

THE FOLLOWING INFORMATION:

- LAB ONLY
- X-RAY ONLY
- COMPLETE MEDICAL RECORDS

I authorize the release of photocopies of the following medical records and/or x-ray files. Records or files shall include all confidential communicable diseases related to information (as defined ARS 36-3661), confidential alcohol or drug abuse related information and confidential mental health diagnosis/ treatment information.

CONCERNING MY TREATMENT AND/OR ILLNESS FROM _____ TO _____

NAME _____

ADDRESS _____

SS# OR DOB _____

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____