

Medical Records Release

Patient Name: _____ **DOB:** ___/___/___

I authorize (doctor or hospital name): _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone (____) _____ Fax (____) _____

To release information from my medical records to:

**Black Mountain Family Medicine, John Bickle D.O.
33755 North Scottsdale Road, Suite 120
Scottsdale, AZ 85262
480-595-8900 FAX: 480-595-8910**

Please release: All records _____

OR from ___/___/___ to ___/___/___

The undersigned authorizes the release of records pertaining to:

- | | |
|--|------------|
| 1. Testing and/or treatment for AIDS and AIDS related diseases | Yes__ No__ |
| 2. Treatment for psychiatric illness | Yes__ No__ |
| 3. Treatment for drug and/or alcohol abuse | Yes__ No__ |

This authorization shall be valid for a period of 90 days (unless revoked earlier).

I hereby waive all provisions of law and privilege relating to the disclosures hereby authorized.

Signature of patient/guardian: _____ **Date:** ___/___/___

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____

Name and relationship if other than self: _____

Office use only: Date received: _____ Date sent: _____ By: _____