Bella Vista Internal Medicine
Jigna Patel, MD PLLC
2680 S Val Vista Dr, Ste 131 Bldg 6
Gilbert, AZ 85296

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I herby authorize the release of photocopies of my medical records in the possession and control of the below named individual/facility, employees and/ or agents for the purpose hereof. Medical records shall include all confidential HIV related information (A.R.S. Section 35-6511); communicable disease related information (A.R.S. Section 36-651); confidential alcohol and drug abuse related information (42CRF Section 2.1 et al); and confidential mental health diagnosis-treatment information unless otherwise directed by me. Description of information to be released (i.e. date of service, test results, immunization records, etc).

_____ **whose date of birth is** _____

Name of Patient **Birth Date**

FROM:

Bella Vista Internal Medicine
Jigna Patel, MD PLLC
2680 S Val Vista DR, STE 131 Bldg 6
Gilbert, AZ 85296
Phone: (480)899-0311 / Fax: (480)814-1462

TO:

_____

_____

_____

Please transfer and/or disclose ALL the following information:

- ○ All medical records, files, charts, reports and other associated health information.
- ○ The following specific Protected Health Information (PHI) (Check ALL that apply)
  - ○ Medical Records & Charts
  - ○ Immunization Records
  - ○ X-Rays or Diagnostic Results/Lab Results
  - ○ Other (Please Specify)_____

TO BE RELEASED FOR:

_____

Printed Patient Name **Date of Birth**

_____

Printed Name of Person Completing Form **Relationship to Patient**

_____

Signature of Person Completing Form **Today's Date**