Dr. Green Clinic
Clinic: 602-500-8400
Fax: 602-325-0107

5210 S. Priest Dr., Ste 5
Tempe, Arizona 85283

330 E. Southern Ave., Ste 28
Mesa, Arizona 85210

MEDICAL RECORDS RELEASE AUTHORIZATION

PLEASE PRINT Today's Date: ____________

Patient Legal Name ____
First *Middle Initial* *Last*

Date of Birth ____________

Address (Street) ____

(City, State, Zip) ____

Mobile Phone ______________________ Home Phone ______________________

To: (Name of your Doctor or Facility) ______________________________________

Address (Street) ____

(City, State, Zip) ____

Phone ______________________ Fax number ______________________

Place a checkmark beside each type of record you are requesting:

√	Last 2-3 progress notes, to include intake notes, diagnoses, treatments & medications
	Laboratory reports for previous 12 months
	Imaging/ radiology reports (please **do not** send films) for previous 12 months
	Biopsy/ surgery reports for previous 12 months
	Other:

Records released for the purpose of: √ Concurrent Care ☐ Other ________________

Please **FAX** the authorized records and information to: **602-325-0107**

I authorize release of the requested medical records to Dr. Green Clinic. I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

I have read the above and authorize the disclosure of the protected health information.

Patient Signature ______________________________________