Medical Records Request

Date: _____

Patient Name:	Date of Birth:
Phone Number:	SSN:
Address:	

☐**I would like my records sent to:**

Digestive Health Clinic:
13128 N. 94th Drive Ste. 201 Peoria, Arizona 85381
Phone Number: 623-209-7227 Fax Number 623-209-7302

From:

Doctors Name:	
Fax Number:	Phone Number:

or

☐ I would like Digestive Health Clinic to send my records to another healthcare provider:

Doctors Name:	
Fax Number:	Phone Number:

or

☐ I would like Digestive Health Clinic to release my records to myself.

I authorize the release of copies of:

☐ All medical records
☐ The last two years
☐ Only those records pertaining to the following:

_____

_____

Sensitive Information:

I understand that this may include information relating to:

☐ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
☐ Behavioral health services, psychiatric care, mental health treatment
☐ Sexually transmitted disease
☐ Diagnosis/treatment for alcohol and or drug abuse

_____

Patient Signature Date