Scottsdale Family Physicians

9755 N. 90th Street, Suite C-200 Scottsdale, AZ 85258 Phone: 480-661-1755 **Fax: 480-661-9636**

AUTHORIZATION FOR MEDICAL RECORD RELEASE

PATIENT NAME: _____

DOB: _____

CURRENT PROVIDER WHO HAS THE MEDICAL RECORD IS:

Name: _____ **(OR)** _____ Marcia Sistek, MD

Address: _____ _____ Jennifer Gamlen, MSN, FNP-C

_____

_____

_____

Phone: _____

Fax: _____

I understand medical records may include confidential information related to HIV, communicable disease, Alcohol or drug abuse, and mental health diagnosis.

I authorize the release of my medical records to:

_____ Marcia Sistek, MD **(OR)** Send records to:

_____ Jennifer Gamlen, MSN, FNP-C Name: _____

Address: _____

FAX: 480-661-9636

_____

_____

_____

Phone: _____

Please send: Fax: _____

____ Visit Notes: last ___ years

____ ECG: last ___ years

____ Lab: last ___ years

____ Path Reports: last ___ years

____ Radiology: last ___ years

____ Other: _____

PATIENT SIGNATURE: _____ **DATE:** _____