Arrowhead Internal Medicine, PC
Tel. (602) 564-0078
Fax. (602) 564-1154

MEDICAL RECORDS RELEASE FORM

Patient Name: ____

Date of Birth ____________________________ Social Security # ________________________

I, ____

Hereby authorize *(Physician's Name)* ______________________________________

Address: ____

____

____

to release of my medical records to:

- ☐ Michael Castro, MD
- ☐ Srivani K Srikantiah, MD

Please mark one:

- ☐ All medical records, including all HIV, AIDS and COMMUNICABLE DESEASES.
- ☐ Medical Records of the past Two (2) years of treatment.
- ☐ Medical Records for period ______________________ to _____________________
- ☐ Only documents pertaining to ______________________________________ diagnosis.
- ☐ Other:____

  ____

This information is needed for the following purpose (s): _______________________________

____

____

Signature____ Date_________________________

Witness____ Date_________________________

I

For office use only:
Date Sent/Received___________________________ By_________________________

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Instructions:

1. Indicate Patients Name, Date of Birth, and Social Security Number.
2. Indicate the name of the Physician who will release your records (where the records are coming from).
3. Mark who you want the medical records to be released to (where the records are going).
4. Indicate what part of the records you want to be released.
5. Indicate the reason you want this records released.
6. Sign and date the form.
7. Any fees are due at the time of request.
8. Please, allow 5 to 7 business days to process your request.