KyreneMedicalCenter

**Internal Medicine**

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# Authorization To Release Medical Records TO Kyrene Medical Center

This information is from confidential records which are protected by State Law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains to, as otherwise permitted by law.

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Last Name | First Name | Middle Initial | |
| Phone Number | Date of Birth | | |
| Address | City | State | Zip |

**INFORMATION TO BE RELEASED**

All records

Selected records only

Mental Health

flIV Testing

lcohol/Substance Abuse

**PURPOSE / FOR INFORMATION**

Changing Physicians

Further Treatment

Insurance Reasons

Other Reason:______________________________

| COPIES TO BE RELEASED FROM | | |
|---|---|---|
| Doctor's Name | Office Name | |
| Address | | |
| City | State | Zip |
| Phone | Fax | |
| Signature of Patient or Legally Authorized Representative | Date | |

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