Arrowhead HEALTH CENTERS | Accredited by the OsteoArthritis Centers of America

MEDICAL RECORDS RELEASE

Patient Last Name, First Name (Please Print) | **Date of Birth (MM/DD/YYYY)**

Patient Social Security Number (000-00-0000)

Patient Home/Cellular Phone (000-000-0000)

☐ I have been informed of and understand that there may be an administrative fee of $35 associated with the printing of my records.

Street Address | **Apt. Number**

City | **State** | **Zip**

Please Release Records to:

Name of Person, Company or Organization | **Phone (000-000-0000)** | **Fax (000-000-0000)**

Business Mailing Address | **Building Number**

City | **State** | **Zip**

Please Release Records From:

Name of Person, Company or Organization | **Phone (000-000-0000)** | **Fax (000-000-0000)**

Business Mailing Address | **Building Number**

City | **State** | **Zip**

I authorize the release of copies of:
☐ The last two years of my medical records
☐ All medical records
☐ Only those records pertaining to (specify types and dates): _____

Sensitive Information:
I understand that this may include information relating to (check to authorize release):
☐ 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
☐ Information for research purpose

Signature of Patient or Responsible Party | **Employee Witness Signature**

Relationship to Patient (If Other Than Self) | **Today's Date (MM/DD/YYYY)**