ARIZONA REPRODUCTIVE MEDICINE SPECIALISTS
1701 E. Thomas Road, Building 1, Suite 101, Phoenix, AZ 85016
Phone: 602.343.2767 Fax: 602.343.2766
www.arizonafertility.com

Patient Name: _____ Date of Birth: _____

Address: _____

Purpose of Disclosure: _____

I authorize _____ to release the following medical records:

O	History and physical	O	Operative Report
O	Pathology Report	O	Laboratory Reports
O	X-ray reports	O	Other (Specify) _____

Records are released to: _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email address: _____

Allow at least seven to ten business days from the date we receive your signed release for your records to be copied and sent out. If the physician or persons listed above has not received your records within ten business days of ARMS receiving your signed request, please contact our office.

First copy of medical records are free of charge, any records requested after the first copy will be a $25.00 charge that will be requested before your records can be processed.

I have read, understand and signed the Patient – Health Care Provider Electronic Communication Agreement and authorize the fax and/or email of my records in accordance to its terms.

Regarding the use of email for transmission of medical records, I understand and agree that ARMS will only email records to me directly and will not email to a third party, such as a doctor's office, friend or relative. I understand that ARMS will only mail or fax records to a third party, such as a doctor's office. By signing below, I acknowledge that the email provided is my own personal email and I authorize ARMS to email my medical records to that email.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will automatically expire six months from date on which it is signed. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of the disclosure.

_____ _____

Signature of Patient Date