



Medical Records Release Form

I HEREBY REQUEST THE A COPY OF PATIENT RECORD AS FOLLOWS:

Name of Doctor from which medical records are being requested: _____

Full Name of Patient: _____
Last Name First Name MI

Maiden Name/Alias: _____
Last Name First Name MI

Patient's Birth Date: _____ E-mail address: _____
Month/Day/Year

Phone Number: (_____) _____ Fax Number: (_____) _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Mail my medical records to the third party at the following address:

Name & Title: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Phone Number: (_____) _____

I hereby authorize A.R.S.C. to charge the following credit card (Master Card, Visa or AMEX) or I have enclosed a check for the amount of **\$44.00** for shipping of the requested medical records.
(Note: Payment by check will take 7-10 business days to process before shipping)

I hereby authorize A.R.S.C. to charge the following credit card (Master Card, Visa, or AMEX) or I have enclosed a check for the amount of **\$35.00** and will personally **PICK UP** the requested medical records.
(Note: Payment by check will take 7-10 business days to process before shipping)

Credit Card #: _____ Expiration Date: ____/____
Month/Year

3 or 4 Digit Security Pin: _____ Billing Zip code of card: _____

Signature of Credit Card holder _____

BY SIGNING BELOW, I HEREBY AFFIRM THAT I AM THE ABOVE DESCRIBED PATIENT, PARENT OR LEGAL GUARDIAN, AND HAVE READ AND FULLY UNDERSTAND ALL STATEMENTS MADE ON THIS DOCUMENT, AND CONSENT TO THE DISCLOSURE OF THE HEALTHCARE INFORMATION FOR THE PURPOSE STATED HEREIN.

Patient's Signature: _____ Date: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Relationship to Patient: _____

NOTARY _____

PLEASE MAIL REQUESTS OR FAX THIS FORM TO:

**Arizona Records Storage Center
7823 W. Golden Lane Peoria, AZ 85345
623-979-3447 623-979-3476 (FAX)**