AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This release authorizes:

Advanced Wound Institute

4915 E Baseline Rd #104
Gilbert, Az 85234

6036 N 19th Ave #204
Phoenix, Az 85015

10147 W Grand Ave #C4
Sun City, Az 85351

Phone: 480-616-0676 Fax: 602-742-0315

To release/receive the information specified below from the medical records department.

________ Doctor's Notes

________ Lab Reports

________ Path Reports

________ Hospital Notes/Consults

________ Other (Please Specify): ________________________________

☐ Mail or ☐ Fax the requested medical records from:

Name/Office: ____

Address: ____

City: ____________________________ State: ________ Zip: _____________

Phone: __________________________ Fax: ___________________________

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature unless I revoke the authorization prior to that time.

Patient Printed Name: ____ **DOB:** __________________________

Patient/legally Authorized Representative: _______________________________ **Date:** _______________