

# Yuma Valley



FAMILY MEDICINE CENTER, PC

Tel: (928) 782-1903

Fax: (928) 782-1703

## Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

### PATIENT INFORMATION (Please print)

|              |      |               |                        |  |
|--------------|------|---------------|------------------------|--|
| Patient Name |      | Date of Birth | Social Security Number |  |
| Address      | City | Zip           | Phone                  |  |

### RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record from

|                    |      |     |       |  |
|--------------------|------|-----|-------|--|
| Physician/Facility |      |     |       |  |
| Address            | City | Zip | Phone |  |

Please send my medical record to:

**FAX 928-782-1703**

|   |                                   |                        |                              |  |
|---|-----------------------------------|------------------------|------------------------------|--|
| Physician/Facility<br><b>Yuma Valley Family Medicine Center, PC</b> |                                   | <b>Dr. Ricky Ochoa</b> |                              |  |
| Address<br><b>2270 S. Ridgeview Drive, Ste 200</b>                  | City/State<br><b>Yuma Arizona</b> | Zip<br><b>85364</b>    | Phone<br><b>928-782-1903</b> |  |

### RELEASE INFORMATION

|  |  |  |
|--|--|--|
| Reason: <input type="checkbox"/> Change of insurance | <input type="checkbox"/> Transfer of care        | <input type="checkbox"/> Personal file |
| <input type="checkbox"/> Moving out of area          | <input type="checkbox"/> Specialist consultation | <input type="checkbox"/> Legal         |

Please release the following (check all that apply)

|                  |                   |
|------------------|-------------------|
| RECENT H&P       | LAST THREE VISITS |
| LAB REPORTS      | X-RAY REPORTS     |
| HOSPITAL REPORTS | OTHER:            |

### CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test results.  
I understand that I may be charged for copies provided.

YES NO Initials

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |

|   |      |
|---|------|
| Signature of patient, parent, guardian, conservator, or patient representative (Please circle.) | Date |
| Witnessed by  | Date |

Note: It may be revoked by the signer at any time.