Form MR602: 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

RELEASE TO: [Name of physician or facility receiving information]

Please send/fax my medical record to:

Physician/Facility IM SPECIALIST, INC (RASHDA KAIF, MD AND FIZZAH SHEIKH, PA-C)			
Address 2737 W BASELINE ROAD SUITE 24	City TEMPE	Zip 85283	Phone/Fax 602-437-4800 602-437-4805 fax

RELEASE INFORMATION

Reason: [ ] Personal file [**X**] Primary Care Physician [ ] Legal
[ ] Moving out of area [ ] Specialist consultation [Other

Please release the following:

[**X**] Entire chart for continuation of care including confidential psychiatric, HIV, alcohol and drug related information

[ ] Specific Information:

- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

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 understand that I may be charged for copies provided.

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

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.