Brown Road Family Medicine, PLLC

David I. Shockey, MD; Nema Runyan, MD; Jeremy Derickson, PA-C; Shea Sullivan, PA-C; Debbie Page, FNP-C
2310 East Brown Road, Mesa, Arizona 85213
Phone: (480) 649-9000 ---- Fax: (480) 248-9213
Email: brfmrecords@outlook.com

MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone#: _____ Cell/Night #: _____

Please Check One Of The Below

_____ I hereby authorize Brown Road Family Medicine to release copies of any and all medical records to me.
(*If it is more than 20 pages it will be on a CD or emailed)*

_____ I hereby authorize Brown Road Family Medicine to release copies of any and all medical records to the Medical Office/Provider/Hospital listed below.

_____ I hereby authorize the Medical Office/Provider/Hospital listed below to release copies of any and all medical records to Brown Road Family Medicine listed above.

MEDICAL FACILITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Phone #: _____ Fax #: _____

***Release the following described medical records only* (SPECIFY TYPES AND DATES)**

____ X-ray_____ ____Laboratory

____ EKG_____ ____ Last Progress Note

____ Other ___ Any and All (past 6 months only)

This consent will expire in sixty (60) days after the signed date below. I may revoke this authorization at any time providing I notify Brown Road Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my right to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

I HEREBY RELEASE BROWN ROAD FAMILY MEDICINE FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

_____ Date _____
Patient Signature

_____ _____
Patient and / or Authorized Representative Relationship to Patient