Scottsdale Gastroenterology Associates
3301 N Miller Rd #138
Scottsdale, AZ 85251
Tel- 480-646-8444 Fax- 480-646-8445

Medical Records Release

Name: _____ DOB: _____ Phone #: _____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

PLEASE OBTAIN INFORMATION FROM:

Janet Reiser, M.D.
3301 N Miller Rd # 138
Scottsdale,AZ 85251

Phone: (480) 646-8444
Fax: (480) 646-8445

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

_____ Entire Record
_____ Immunization Record
_____ Lab Tests
_____ TB Test
_____ HIV Record
_____ STD Record
_____ Psychiatric/Mental Health
_____ Alcohol/Substance Abuse
_____ Billing Records
_____ Other: _____

REASON for disclosure of health information: (Please initial)

_____ At my request
_____ Continuing Care
_____ Insurance
_____ Other (please specify) _____

EXPIRATION of this Authorization (Please initial)

_____ 90 days after signature date
_____ On this date: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws

_____
Patient Signature

_____
Date

Pick-Up Records Mail Records Fax Records