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 OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ **Fax:** _____

PLEASE SEND INFORMATION TO:

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