NextCare PRIMARY CARE

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NextCare Primary Care
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Records Release Authorization

Patient name _____

Address _____

_____

Date of Birth _____

Choose one: I authorize the release of records

__ **To** NextCare Primary Care **from**:

_X_ **From** NextCare Primary Care **to**:

The following information must be complete in order to obtain records

Provider's Name / Office _____

Address _____

_____

Phone _____ Fax _____ **REQUIRED

Choose one

_X_ All medical records - including notes, labs, imaging, etc. (Last two years)

__ Office notes only (Last two years)

__ The following described records only (specify type and dates):

_____

_____

I authorize the release of records concerning my medical treatment including confidential HIV-Related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ), and confidential mental health diagnosis/treatment information.

This authorization expires in one year unless revoked in writing earlier.

I _X_ am __ am not transferring my care to a new primary care physician.

Patient or authorized signer _____ Date _____