Request for Medical Records
Release of Information

We would like to request a copy of the medical records for the following patient:

According to the **Arizona Revised Statues, §12-2294, paragraphs A-F** (which are cited, in part, here):

A. A health care provider shall disclose medical records, or payment records, or the information contained in [the] medical records or payments records, **without** the patient's written authorization, as otherwise required by law, or when ordered by a court or tribunal of competent jurisdiction.

B. A health care provider may disclose medical records or payment records, or the information contained in medical records or payment records, pursuant to written authorization signed by the patient or the patient's health care decision maker.

C. A health care provider may disclose medical records, or payment records, or the information contained in [the] medical records or [the] payment records **without** the written authorization of the patient or the patient's health-care-decision-maker as otherwise authorized by state or federal law, including the health insurance portability and accountability act privacy standards (45 Code of Federal Regulations part 160 and part 164, subpart 3), or as follows:

1. To health care providers who are currently providing health care to the patient for the purpose of diagnosis or treatment of the patient.

2. To health care providers who have previously provided treatment to the patient, to the extent that the records pertain to the provided treatment. . .

Please mail, or fax, the requested records to:

Jay M. Crutchfield, MD, FACS
PO Box 10997
Prescott, Arizona 86304-0997

Phone: 928-776-9101
Facsimile: 928-776-8530

By this letter, I, the undersigned, request, and give permission for any, or all, of my medical records to be released to Dr. Crutchfield and/or his agents.

Patient's Name________________________________ SSN____________________ DOB____________

Address____

City____State_________________Zip Code____________

Patient's Signature (or legal representative)____

Approximate Date of the Records being requested:____

This request shall remain valid until revoked by the patient by providing the revocation date below.

Date of Revocation____