702 S. Main Street
Cottonwood, AZ 86326

Phone: (928) 649 – 0269
Fax: (866) 644 – 6363

office@breakthroughmed.com
www.breakthrough-medicine.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Legal Name _____ Date of Birth _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____

I hereby authorize release of my medical records ☐ **TO** or ☐ **FROM:**

_____

(current physician's name and contact information)

to disclose protected health information of the person listed above, to:

Breakthrough Medicine - FAX (866) 644- 6363

Type of access requested (copies of the records):

☐ Entire record	☐ Nursing notes	☐ ER records
☐ Imaging/radiology	☐ History and physical	☐ Consult reports
☐ Operative reports	☐ Rehabilitation services	☐ Immunizations
☐ Laboratory reports	☐ Cardiac studies	☐ Demographics
☐ Progress notes	☐ Physician's orders	
☐ Medication records	☐ Other_____	

1. I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
2. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
3. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
4. I understand that there may be a fee involved with the fulfillment of this request.
5. I understand that the term, ***entire record***, regarding release of protected Health Information means that only records generated by the named facility will be released.
6. I have read the above and authorize the disclosure of the protected health information.

_____ _____

Signature of Patient/Parent/Legal Guardian Date