EQUALITY
CARE CENTER™

4220 N. 20th Avenue Phoenix, AZ 85015
3306 W. Roosevelt St. Phoenix, AZ 85009

Chart #: ____________________

RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

Address: ______________________________

Phone: ______________________________

Please provide the name and contact information for your Primary Care Provider:

To release to ______________________________
(Name of facility and/or person to receive records)

Address: ______________________________

Phone: ______________________________ Fax: ____________________

Information to Release:

☐ Progress Notes ☐ Medication List ☐ Mental Health ☐ Consultations

☐ Labs results/pathology reports ☐ Physical Therapy ☐ Imaging Reports

☐ Hospital Records/Discharge Summaries ☐ HIV/AIDS or Communicable diseases

☐ Alcohol/drug treatment

☐ Other (please specify Dates): ______________________________

☐ All records (please specify Dates): ______________________________

Reason for request is:

☐ Personal Records ☐ Continuity of Care ☐ Legal

☐ Other: ______________________________

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand the information can be released orally or in the form of written records as preferred by the requester. I have the right to inspect any written records released pursuant to this request.

Name: ______________________________ Relationship to Patient: ____________________

Phone: ______________________________

Signature of Patient: ______________________________ Date: ____________

Signature of Parent or Guardian: ______________________________ Date: ____________

ECC Signature: ______________________________ Date: ____________

ECC Printed Name: ______________________________ Date: ____________