

Dear Patient,

Thank you for choosing me as your primary care physician. I am Board Certified in Internal Medicine and Pediatrics. And while I am temporarily taking a break from seeing my own hospital patients, I do have privileges at Banner Baywood and Banner Heart Hospitals. I work closely with Phoenix Children's Hospital in transitioning pediatric special needs patients to adult care. I am also an Associate Medical Director for Endeavor Hospice.

I take Medicare, Tricare, most Medicare Advantage Plans, supplemental plans, commercial plans, ACA and AHCCCS plans.

I have a full-time Physician Assistant on staff and patients are expected to see the PA when I am not available. However, all patients must be seen by me every third visit, or a minimum of once a year.

**RUNNING LATE-** I RUN LATE. While I understand your time is valuable, this is something that cannot be helped due to the nature of my practice. I will never rush a patient to stay on schedule. And while I may run late, the staff must stay on schedule when rooming patients. If you arrive late and I have moved past your appointment time, you will need to reschedule.

**PATIENT PORTAL-** We offer a patient portal for communicating with office staff. If you need assistance setting up the portal, our front office will be able to assist you.

**INSURANCE** - You must present your insurance card at each visit and pay any copay or remaining deductible at the time of your visit.

**PATIENT PHOTO** – All patients are required to have a photo taken for their chart.

**MEDICATION PRIOR AUTHORIZATIONS** - Depending upon your insurance, certain medications may require prior authorization. If an appropriate alternate medication is available, it will be substituted; if not, and a prior authorization is needed, an appointment will be necessary to document its medical necessity and submit the prior authorization.

**TEST RESULTS** - Any labs or tests ordered will require a follow-up appointment to discuss results.

**REFERRALS** - Requests for new referrals require an appointment. We use a centralized referral system to locate specialists who take your insurance. If a referral is rejected by the specialist, you must contact your insurance company for the name of an in-network specialist, and a new referral will be processed. Please allow 3 days for a referral to be submitted.

**PRESCRIPTION REFILLS** - All prescriptions are sent electronically. We do not respond to faxed requests. All patients on chronic medications require an appointment every six months.

**CONTROLLED SUBSTANCES** - All Schedule 1, 2 and 3 controlled substances require an in-office monthly appointment. At the time of your appointment your next monthly appointment must be scheduled. Failure to schedule your next appointment will not guarantee that you can be seen before you run out of your medication.

**MEDICAL RECORDS** - There is a \$25 fee for copying medical records unless the request is made by another physician for continuity of care. All records will be supplied in CD format and will be completed within 7-10 business days.

**FORMS** - Forms to return to work, FMLA paperwork, school physicals, disability paperwork, etc. Requires a separate visit to address the paperwork and cannot be combined with other appointments. Please allow 7 business days for final completion of the form. If an exception is made and the form is completed outside of a visit, the charge for simple forms is \$25 fee and for more complicated forms (more than 3 pages) the fee is \$60.

**BILLING** – All billing questions should be directed to our inhouse biller who can be reached at 480-930-4600, option 5.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NEW PATIENT PACKET

PERSONAL INFORMATION

|                                                                         |                                                                                |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Name                                                                    | DOB                                                                            |
| Address                                                                 | Social Security#                                                               |
| City State Zip                                                          | Marital Status                                                                 |
| Phone                                                                   | Race                                                                           |
| Email                                                                   | Ethnicity                                                                      |
| Winter Visitor <input type="checkbox"/> Yes <input type="checkbox"/> No | Gender                                                                         |
| Address#2                                                               | Language                                                                       |
| City State Zip                                                          | Is Interpreter Needed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Phone#2                                                                 | Occupation                                                                     |
| <b>Emergency Contact Information</b>                                    |                                                                                |
| Name                                                                    | Phone                                                                          |
| Relationship to Patient                                                 | Email                                                                          |

INSURANCE INFORMATION

☐ I DO NOT HAVE INSURANCE. I understand that all fees must be paid at the time of service.

| PRIMARY INSURANCE                                 | MEMBER ID | GROUP ID | POLICYHOLDER | POLICYHOLDER DOB |
|---------------------------------------------------|-----------|----------|--------------|------------------|
|                                                   |           |          |              |                  |
| SECONDARY INSURANCE                               |           |          |              |                  |
|                                                   |           |          |              |                  |
| RX(PARTD) INSURANCE                               |           |          |              |                  |
|                                                   |           |          |              |                  |
| MEDICARE (Required if on Medicare Advantage Plan) |           |          |              |                  |
|                                                   |           |          |              |                  |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PERSONAL HEALTH HISTORY AND HEALTH RISK ASSESSMENT

Primary Concern for this appointment: \_\_\_\_\_

Allergies/Medication Reactions

| Type of Allergy or Medication | Describe Reaction |
|-------------------------------|-------------------|
|                               |                   |
|                               |                   |
|                               |                   |

Current Medications - or attach copy of current med list

| Medication/Strength (ex: lisinopril 10 mg) | Dosing (ex: 1 tablet daily) | Reason (ex: high <b>blood</b> pressure) |
|--------------------------------------------|-----------------------------|-----------------------------------------|
|                                            |                             |                                         |
|                                            |                             |                                         |
|                                            |                             |                                         |
|                                            |                             |                                         |
|                                            |                             |                                         |

Other Healthcare Providers- List all healthcare providers who have treated you in the last 3 years:

| Name of Provider | Specialty | City, State & Phone | Condition Treated & When |
|------------------|-----------|---------------------|--------------------------|
|                  |           |                     |                          |
|                  |           |                     |                          |
|                  |           |                     |                          |
|                  |           |                     |                          |
|                  |           |                     |                          |
|                  |           |                     |                          |

Previous Hospitalizations and Surgeries:

| Name of Provider | Hospital | City, State & Phone | Condition Treated & When |
|------------------|----------|---------------------|--------------------------|
|                  |          |                     |                          |
|                  |          |                     |                          |
|                  |          |                     |                          |
|                  |          |                     |                          |

Family History- Please check all that apply and give the relationship to family member:

|                                               |                                           |
|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Heart Attack     |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Hypertension     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Lupus            |
| <input type="checkbox"/> Breast Cancer        | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Colon Cancer         | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Skin Cancer          | <input type="checkbox"/> Cystic Fibrosis  |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Other            |

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**Caffeine, Alcohol, Tobacco and Drug Use- Do you use any of the following:**

**Caffeine**      ☐ Yes    ☐ No    If yes, how many caffeinated beverages to you drink daily? \_\_\_\_\_  
(example: 2 regular cups of coffee daily)

**Alcohol**      ☐ Yes    ☐ No    If yes, how much and how often do you drink alcohol? \_\_\_\_\_  
(example: 2 4-oz glasses of wine weekly)

**Tobacco**      ☐ Yes    ☐ No    ☐ Former tobacco user    If yes, or former tobacco user, please answer the following:

|                                                               |  |
|---------------------------------------------------------------|--|
| When did you quit using tobacco and for how long did you use? |  |
| Type of tobacco (cigarettes, cigars, snuff, chew)             |  |
| How long have you been smoking?                               |  |
| How much and how often do you smoke? (example: one pack/day)  |  |

**Drugs**      ☐ Yes    ☐ No    ☐ Former drug user    If yes, former drug user, please answer the following:

|                                                              |  |
|--------------------------------------------------------------|--|
| When did you stop using drugs and for how long did you use?  |  |
| Type of drug (IV, marijuana, cocaine, crystal meth, opioids) |  |
| How long have you been using drugs?                          |  |
| How much and how often do you use drugs?                     |  |

**HIV/AIDS Risk- Please answer the following questions:**

Have you ever had a blood transfusion?      ☐ YES      ☐ NO  
Have you used IV drugs in past 10 years?      ☐ YES      ☐ NO  
Have you had unprotected sex in past 10 years?      ☐ YES      ☐ NO  
Have you had multiple sexual partners in past 10 years?      ☐ YES      ☐ NO

**Other Health Behaviors**

Do you do self-breast/testicular exams?      ☐ YES      ☐ NO  
Do you wear your seatbelt regularly?      ☐ YES      ☐ NO  
Do you wear sun protection regularly?      ☐ YES      ☐ NO  
Do you have annual vision exams?      ☐ YES      ☐ NO  
Do you have regular dental exams?      ☐ YES      ☐ NO  
Do you exercise regularly?      ☐ YES      ☐ NO  
Do you have a smoke detector in your home?      ☐ YES      ☐ NO

**Psychological History - Please indicate if you now have, or in the past have ever, experienced the following:**

**C = CURRENT    P = PAST    N = NEVER**

Depression \_\_\_\_\_  
Mania/Psychosis \_\_\_\_\_  
Suicidal/Homicidal Thoughts \_\_\_\_\_  
Sexual Abuse \_\_\_\_\_  
Physical Abuse \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**System Review - Please check any symptom you currently have or that has been a recurring problem**

|                                                         |                                                    |                                              |                                                |
|---------------------------------------------------------|----------------------------------------------------|----------------------------------------------|------------------------------------------------|
| <b>GENERAL</b>                                          | <b>SKIN/INTEGUMENT</b>                             | <b>HEAD/NECK</b>                             | <b>GASTROINTESTINAL</b>                        |
| <input type="checkbox"/> Dizziness                      | <input type="checkbox"/> Bruising                  | <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Abdominal Pain        |
| <input type="checkbox"/> Excessive Thirst               | <input type="checkbox"/> Eczema                    | <input type="checkbox"/> Dental Pain         | <input type="checkbox"/> Black/Tarry Stools    |
| <input type="checkbox"/> Fainting                       | <input type="checkbox"/> Hives                     | <input type="checkbox"/> Double Vision       | <input type="checkbox"/> Bloating/Gas          |
| <input type="checkbox"/> Fatigue                        | <input type="checkbox"/> Itchiness                 | <input type="checkbox"/> Ear Ringing         | <input type="checkbox"/> Blood in Stool        |
| <input type="checkbox"/> Fever                          | <input type="checkbox"/> Rash                      | <input type="checkbox"/> Eye Infections      | <input type="checkbox"/> Change in Bowels      |
| <input type="checkbox"/> Sleep Problems                 | <input type="checkbox"/> Moles                     | <input type="checkbox"/> Eye Pain/Floaters   | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Weight Gain                    | <input type="checkbox"/> Psoriasis                 | <input type="checkbox"/> Jaw Pain            | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Weight Loss                    |                                                    | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Mood Swings                    | <b>CARDIAC/CIRCULATION</b>                         | <input type="checkbox"/> Head Injury         | <input type="checkbox"/> Heartburn             |
|                                                         | <input type="checkbox"/> Angina                    | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Loss of Appetite      |
| <b>NERVOUS SYSTEM</b>                                   | <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> Hoarseness          | <input type="checkbox"/> Painful Swallowing    |
| <input type="checkbox"/> Anxiety/Nervousness            | <input type="checkbox"/> Chest Pressure            | <input type="checkbox"/> Mouth Sores         | <input type="checkbox"/> Persistent Nausea     |
| <input type="checkbox"/> Chronic Pain                   | <input type="checkbox"/> Chest Tightness           | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Irregular Pulse           | <input type="checkbox"/> Swollen Lymph Nodes |                                                |
| <input type="checkbox"/> Knocked Unconscious            | <input type="checkbox"/> Leg Pain (walking)        | <input type="checkbox"/> Neck Swelling       | <b>MUSCULAR SKELETAL</b>                       |
| <input type="checkbox"/> Memory Loss                    | <input type="checkbox"/> Murmur                    | <input type="checkbox"/> Nosebleeds          | <input type="checkbox"/> Joint Pain            |
| <input type="checkbox"/> Mental Illness                 | <input type="checkbox"/> Palpitations              | <input type="checkbox"/> Sinus Infections    | <input type="checkbox"/> Muscle Weakness       |
| <input type="checkbox"/> Numbness/Tingling              | <input type="checkbox"/> Swollen Ankles            | <input type="checkbox"/> Sore Throat         | <input type="checkbox"/> Joint Swelling        |
| <input type="checkbox"/> Phobias                        | <input type="checkbox"/> Varicose Veins            |                                              | <input type="checkbox"/> Joint Deformity       |
| <input type="checkbox"/> Seizures                       |                                                    | <b>DO YOU WEAR/USE</b>                       | <input type="checkbox"/> Muscle Wasting        |
| <input type="checkbox"/> Tics                           | <b>GENITOURINARY</b>                               | <input type="checkbox"/> Dentures            | <input type="checkbox"/> Muscle Pain           |
|                                                         | <input type="checkbox"/> Blood in Urine            | <input type="checkbox"/> Glasses/Contacts    |                                                |
| <b>PULMONARY</b>                                        | <input type="checkbox"/> Genital Discharge         | <input type="checkbox"/> Hearing Aid         | <b>OTHER</b>                                   |
| <input type="checkbox"/> Cough                          | <input type="checkbox"/> Sexual Dysfunction        | <input type="checkbox"/> Cane                |                                                |
| <input type="checkbox"/> Blood in Sputum                | <input type="checkbox"/> Decreased Urine Control   | <input type="checkbox"/> Walker              |                                                |
| <input type="checkbox"/> Wheezing                       | <input type="checkbox"/> Painful Urination         | <input type="checkbox"/> Wheelchair          |                                                |
| <input type="checkbox"/> Shortness of Breath (Resting)  | <input type="checkbox"/> Decreases Urine Stream    |                                              |                                                |
| <input type="checkbox"/> Shortness of Breath (Exertion) | <input type="checkbox"/> Increased Urine Frequency |                                              |                                                |
| <input type="checkbox"/> Shortness of Breath (Lying)    |                                                    |                                              |                                                |
|                                                         |                                                    |                                              |                                                |

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**Past Medical History- Please check all that apply and give date condition began**

|                                                |                                             |                                           |
|------------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Constipation     |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Blood Clots        | <input type="checkbox"/> Crohn's Disease  |
| <input type="checkbox"/> Anxiety/Depression    | <input type="checkbox"/> Cancer: Type       | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Arthritis- Osteo      | <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Eating Disorder  |
| <input type="checkbox"/> Arthritis- Rheumatoid | <input type="checkbox"/> Chronic Back Pain  | <input type="checkbox"/> Emphysema        |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Fibromyalgia     |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Chronic Diarrhea   | <input type="checkbox"/> Gallstones       |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Colon Polyps       | <input type="checkbox"/> Gout             |
| <input type="checkbox"/> Headache              | <input type="checkbox"/> Hearing Loss       | <input type="checkbox"/> Heart Failure    |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Heartburn          | <input type="checkbox"/> Hemorrhoids      |
| <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> HIV/AIDS         |
| <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Kidney Failure   |
| <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Ovary Problems   |
| <input type="checkbox"/> Pancreatitis          | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Prostate Problems     | <input type="checkbox"/> Psoriasis          | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Shingles         |
| <input type="checkbox"/> Skin Lesions          | <input type="checkbox"/> Stomach Ulcers     | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Testicular Problems   | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Ulcerative Colitis    | <input type="checkbox"/> Valley Fever       | <input type="checkbox"/> Vision Problems  |
| <input type="checkbox"/> Other:                | <input type="checkbox"/> Other:             | <input type="checkbox"/> Other:           |

**FOR FEMALES ONLY- Gynecologic History**

|                                                               |                                                                                  |
|---------------------------------------------------------------|----------------------------------------------------------------------------------|
| Age at onset of menses                                        | Miscarriages                                                                     |
| Length of monthly cycle                                       | Abortions                                                                        |
| Length of menstruation                                        | Menopause was <input type="checkbox"/> natural <input type="checkbox"/> surgical |
| Date of last menstrual period                                 | Date of last pap smear                                                           |
| Cycle is            regular            Irregular              | Was pap            normal            abnormal                                    |
| Flow is            light            moderate            heavy | Date of last mammogram                                                           |
| Number of pregnancies            Live births                  | Was mammogram    normal            abnormal                                      |

PatientName \_\_\_\_\_ DOB \_\_\_\_\_

**PREVENTATIVE SCREENING**

| <i>Type of Screening</i>                              | <i>location</i> | <i>Date of</i> |
|-------------------------------------------------------|-----------------|----------------|
| Colonoscopy                                           |                 |                |
| Cologuard                                             |                 |                |
| FOBT                                                  |                 |                |
| Mammogram                                             |                 |                |
| DEXA (Bone Density)                                   |                 |                |
| PAP                                                   |                 |                |
| PSA & digital rectal exam                             |                 |                |
| ECHO                                                  |                 |                |
| CT cancer screening                                   |                 |                |
| Diabetic eye exam                                     |                 |                |
| PFT (Spirometry) (for patients with COPD)             |                 |                |
| NIOX (for patients with asthma)                       |                 |                |
| Cognitive Testing (for patients with memory concerns) |                 |                |
| Chest x-ray                                           |                 |                |
| EKG                                                   |                 |                |
| AAA                                                   |                 |                |
| Treadmill Stress Test                                 |                 |                |
| ABI                                                   |                 |                |
| Cardiac Catheterization                               |                 |                |
| Cholesterol Lab                                       |                 |                |

**IMMUNIZATIONS**

| <i>Vaccine</i>                | <i>Date(s) Given</i> | <i>Where Given</i> |
|-------------------------------|----------------------|--------------------|
| Flu                           |                      |                    |
| Pneumonia PPSV23              |                      |                    |
| Pneumonia PCV13               |                      |                    |
| Pneumonia PCV15               |                      |                    |
| Pneumonia PCV20               |                      |                    |
| Tdap (Tetanus)                |                      |                    |
| Shingles                      |                      |                    |
| RSV                           |                      |                    |
| COVID-19 (last date received) |                      |                    |
| Hep A                         |                      |                    |
| Hep B                         |                      |                    |

## HIPAA & Privacy Guidelines

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **What Is HIPAA?**

The Health Insurance Portability and Accountability Act (HIPAA) was passed to protect the confidential medical and billing records of our patients. A particularly important element of HIPAA regulation pertains to the patients' rights related to access and control of their medical information. We count on all members of Gerard B Chamberlin, MD MPH PC to incorporate the HIPAA rules into their daily activities. Our patients have a right to privacy. We are committed to complying with HIPAA, not only because it is the law, but also because we value our patients and their privacy.

The Privacy Rule (45 CFR Part 160 and Subparts A & E of Part 164) provides the first comprehensive Federal protection for the privacy of health information. All segments of the health care industry have expressed support for the objective of enhanced patient privacy in the health care system. The Privacy Rule, as modified, is carefully balanced to provide strong privacy protections that do not interfere with the patient's access to, or the quality of, health care delivery.

### **Acknowledgment of Notice of Privacy Practices:**

*I acknowledge, by signing below, that a copy of this office's Notice of Privacy Practices is available to me that outlines how a patient's confidential information will be used, disclosed, and protected.*

### **Acknowledgment of Notice of Health Information Practices:**

*I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in another Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.*

### **Consent For Electronic Medication History Download**

I give Gerard B Chamberlin, MD MPH PC, and its employees permission to download my electronic prescribing history into our electronic health record, when available, for the purpose of improved clinical care. This information will be included in the permanent medical record and will only be shared with the persons, groups, or affiliations that have legal access to the patient's medical record. This information will help us avoid potential drug-drug interactions, prescribe appropriate medications and take better care of our patients. Policies and Procedures related to Health Insurance Portability and Accountability Act (HIPAA), which safeguards medical information, will be maintained.

Is this patient a Minor (under 18 years of age)? ☐ YES ☐ NO

Is the patient a legal dependent (over 18 years of age, however, legally a dependent) ☐ YES ☐ NO

\_\_\_\_\_  
Patient Signature (if minor or adult dependent- Parent Legal Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient if patient is a minor or adult dependent  
(documentation may be requested)

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**PROTECTED HEALTH INFORMATION (PHI) COMMUNICATION AUTHORIZATION**

I hereby give permission to receive voicemail messages containing the following information:

☐ Appointments/Scheduling                      ☐ Notification that test results are available                      ☐ Test results

I hereby revoke all prior PHI authorizations and give permission to the person(s) listed below to discuss my protected health information (PHI) as it relates to my care or treatment. NOTE: This permission does not authorize the person(s) listed below to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical records.

We will NOT release via telephone or other means of communication any information to friends or family members that are not listed below, unless the patient has been given the opportunity to object to such release of PHI, unless it is reasonable to infer that patient does not object (as when patient brings a spouse or others into the exam room when treatment is being discussed). The only EXCEPTION is when the provider deems it necessary in an emergency.

| Name  | Phone Number | Relationship |
|-------|--------------|--------------|
| _____ | _____        | _____        |
| _____ | _____        | _____        |
| _____ | _____        | _____        |
| _____ | _____        | _____        |

\_\_\_\_\_ DATED \_\_\_\_\_

Signature of Patient or Guardian

Patient Signature: \_\_\_\_\_ .DOB: \_\_\_\_\_

**MEDICAL RECORDS REQUEST**

**(this section to be completed by provider as needed)**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

To: \_\_\_\_\_ FAX: \_\_\_\_\_

|                          |                   |
|--------------------------|-------------------|
| Complete Medical Records | Progress Notes    |
| Last 3 Visit Notes       | Imaging/X-Results |
| Lab Results              | Other             |

Notes:

Please FAX or mail records to:

**FAX: 480-930-4615**

Gerard B Chamberlin, MD MPH PC

6242 E Arbor Avenue, Suite 123

Mesa, AZ 85206

Phone: 480-930-4600

**(Patient Authorization - to be signed by Patient or Guardian)**

**(a copy is as valid as an original)**

Patient or Guardian Signature: \_\_\_\_\_

If Guardian, relationship to patient \_\_\_\_\_