Desert Star Healthcare, LLC
4855 E. Brown Rd Suite 100
Mesa, AZ 85205
Phone (480)219-6646 Fax (480)219-6647
www.desertstarhealthcare.com

Medical Records Release

Patient Name:____ **Date of Birth**_______________

Address____

City____State___________Zip____________________

Phone:_________________________

I, ____ authorize the following healthcare provider/facility to release the requested medical records for the purpose of continued care or other reasons as specified:____

Healthcare Provider/Facility: ____

Address____

City____State___________Zip____________________

Office Phone:_________________________ Office Fax:_________________________________

Records to be released:

	Office Visit Notes		Lab & Pathology Results		Imaging Reports
	EKGs		Immunizations		Operative Reports
	Discharge Summary		All Records for:		
	ALL Available Records		Other:		

Please provide the above records via fax or secure messaging EMR system to:

Desert Star Healthcare, LLC
4855 E. Brown Rd. Suite 100
Mesa AZ 85205
Phone (480) 219-6646 Secure Fax (480) 219-6647

I understand that I have the right to revoke this authorization at any time by notifying either party in writing. The written revocation must be signed and dated. The revocation will not affect any actions taken prior to the date of receipt of the revocation. This authorization will expire in one (1) year, unless otherwise specified by date or event: ____________________

I understand that this authorization is voluntary and I may refuse to sign this form without any affect on my healthcare or payment for my healthcare.

I understand that I will receive a copy of this after signing and it is viewable through my patient portal.

Patient
Signaure____Date_____________

Relationship if other than patient is signing: ____