Ellen F Bunch MD

The Healthcare You Need • The Attention You Deserve

RELEASE OF MEDICAL RECORDS

CONSENT TO RELEASE or RECEIVE
CONFIDENTIAL and/or SENSITIVE INFORMATION

NAME _____DATE_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE_____ _____ SSN _____-_____-_____

I, _____ DOB: _____/_____/_____

Hereby authorize: Ellen Bunch, M.D.
1530 W Cliff Rose Rd
Prescott, AZ 86305
(928) 777-8880 phone
(928) 777-8884 fax

_____ to release to:

_____ to receive from:

PLEASE NOTE: Adobe Acrobat (PDF) digital records are preferred. File(s) can be emailed as an attachment to info@ima-az.com or copied to CD and mailed. Other electronic file types are accepted (i.e. TIFF, et al). Please call office if needed. Thank You!

_____
(physician's name and facility)

_____
(address) (city) (state) (ZIP)

_____
(phone) (fax)

____ Complete Medical Records

____ Summary of Medical Care
____ Doctor's Orders
____ Phone Contacts
____ Letters & other Written Correspondence
____ Progress Notes
____ History and Physical
____ Continued Care Plan
____ Other
____ Medical Discharge Summary
____ X-Ray Reports
____ Consultations

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. In any event, if no expiration date is specified above this consent will automatically expire one year from the date noted below. The Federal Regulations of Confidentiality of Alcohol or Drug Abuse Patient Records (42 CFR Part 2) and State Law protecting the confidentiality of patient records that has been explained to me.

_____
(Patient's Full Name – please print)

_____
(Patient Signature) (Parent/Legal Guardian)

_____
(Witness Signature) (Date)