Gary A. Smith, MD, PLLC *Tracy L. Jones, MS, PA-C*

RECORDS RELEASE AUTHORIZATION

TO:____ ______________________________
(PHYSICIAN'S NAME) (PHONE NUMBER)

____
(ADDRESS)

____
(CITY) (STATE) (ZIP CODE)

I hereby authorize the release of photocopies of the following medical records and/or x-ray films in the possession of the above facility. Medical records and x-ray films shall include HIV related information (A.R.S. Sec. 36-661), communicable disease information (A.R.S. Sec. 36-661), alcohol or drug abuse related information (42 CFR sec. 2.1 ET SEQ) and confidential mental health treatment and diagnosis information.

I **do** / **do not** (please circle) consent to the release of HIV-(AIDS) related information as part of this authorization.

[ ] All Medical Records	[ ] Office Notes Only	[ ] Lab Work Only
[ ] X-Ray Reports	[ ] Referral Records Only	[ ] Hospital Records Only

[ ] Specific Medical Records (please list date, records, etc.):

Patient Name & Address:	
________________________________	Date of Birth: ________________________
________________________________	S.S. #: ________________________
________________________________	Phone #: ________________________

I hereby request that my medical records be released to:

- ❑ **GARY A. SMITH, MD, FAAFP**
- ❑ **TRACY L. JONES, MS, PA-C**

7400 S. Power Road, Bldg. 5, Suite 120
Gilbert, AZ 85297
Phone: (480) 988-1659
Fax: (480) 988-1871

Patient Signature ______________________________________ Date ____________________

Witness ____ Date ____________________