tatum
highlands
medical associates

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____

I authorize the facility listed below to release my records to Tatum Highlands Medical Associates. Please send the following (check all that apply)**:**

✔	**Complete Medical Records**	✔	**Progress Notes**
✔	**Lab/Pathology Reports**	✔	**Immunization Records**
✔	**Cardiology/EKG Reports**	✔	**Imaging Reports**

Practice/Facility	
Street Address	
City, State, Zip	
Phone Number	
Fax Number	

I understand that authorizing the release of medical records and personal health information is voluntary and therefore I release Tatum Highlands Medical Associates, their providers, and their employees from any and all liabilities, damages, and claims which may arise from the release of information. In addition, I understand that disclosure of this information may not be protected by federal confidentiality rules and my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, human immunodeficiency, behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization may be revoked at any time, however the revocation must be submitted in writing to Tatum Highlands Medical Associates and does not apply to health information previously released.

Patient Signature: _____ **Date:** _____

Please send records via <u>mail, fax, or secure, encrypted email</u> to:

MAIL

Tatum Highlands Medical Associates
26224 N. Tatum Blvd. Suite 15A
Phoenix, AZ 85050

Paper copies only!
<u>No CDs, please.</u>

FAX

480-419-6782

EMAIL

If you wish to send electronic records please email attachments in **PDF FORMAT** to our secure email at:

admin@secure.tatummedical.com