MEDICAL RECORDS REQUEST

Patient Name: _____ Date:_____
Date of Birth: _____ SSN:_____
Home Phone: _____ Cell Phone:_____
Address: _____
City/State/Zip: _____

Hospital or Facility Information
Facility Name:_____
Facility Address:_____
City/State/Zip:_____
Facility Phone Number:_____
Facility Fax Number:_____

☐Records To Aveon Health
7699 East Pinnacle Peak Road, Suite 115
Scottsdale, AZ 85255
480-300-GOMD (4663), 480-300-4888 (FAX)

OR

☐Records From Aveon Health
7699 East Pinnacle Peak Road, Suite 115
Scottsdale, AZ 85255
480-300-GOMD (4663), 480-300-4888 (FAX)

I authorize the release of copies of:
□ All Medical Records
□ The Last Two Years
□ Only those records pertaining to the following:
_____

Sensitive Information:
I understand that this may include information relating to:
□ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
□ Behavioral health services, psychiatric care, mental health treatment
□ Sexually transmitted disease
□ Diagnosis/treatment for alcohol and/or drug abuse Information for research purpose

Patient/Responsible Party Signature:_____ **Date:**_____