edicine
Internal Medicine

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I,_____DOB: _____
Patient Name

_____SS# _____
Patient Address

authorize _____
Name of Physician, Practice, Facility, etc.

to provide: **edicineIM**
34597 N 60th Street, Suite 110
Scottsdale, AZ 85266-5240

with the following documents (state specific documents, time period, etc.):

_____

Purpose or need for the information requested:

Continued Care _____ Insurance _____ Legal _____ Transfer _____ Personal _____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____ _____
Patient/Parent/Legal Guardian Signature Relationship Date

_____ _____
Witness Signature Date

If signed by other than patient, state relationship and reason for patient's inability to sign.

A copy of this authorization has been _____ accepted _____ rejected by the patient/representative. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

Office Use Only:

edicine
Internal Medicine

Please read these instructions carefully before completing the BMA Patient Authorization to Release Medical Records Form:

Patient Name: Patient Name used at time of care (maiden, married, etc.)

Patient Date of Birth: Complete: month- day – year

Social Security #: Complete: all 9 digits ex: 000-00-0000

Patient Address: Complete current address: House #, RR #, Box #, Street, City, State, Zip Code

Authorize: Complete name of physician, facility, address, zip code of where the record is currently housed.

To Provide: Complete name of physician, facility, company, person, etc., address, zip code of where you want the records sent.

Information to be released/requested: State specific time periods, documents, etc. Example: All office notes 6-1-14 through present, x-ray/pathology/lab & diagnostic reports from 6-1-06 through present, MRI report done 6-1-06, etc. If specific dates/times are not requested, we will send last year of office visits, 6 months of lab reports (from last lab done) and 5 years of diagnostic reports. **We do not honor blanket authorizations for "any and all medical records"**.

Purpose or need for the information request: Please place a mark beside one of the five categories listed. Example: If records are for an appointment with a specialist you will mark "Continued Care". If you are no longer a patient of BMA and want your records forwarded to another physician, please mark "Transfer".

Consent: Please read complete statement before signing

Patient Signature/Relationship/Date: Patient/guardian/representative full name, if signed by patient, "self" will be the relationship. If signed by someone other than the patient, state relationship to patient: guardian/representative, etc. A valid authorization must be dated. If signed by other than patient, state relationship and reason for the patient's inability to sign in space available toward the bottom of the form.

Witness Signature/Date: Complete name of witness and date witnessed.

*If you wish to receive copy of this authorization, please indicate by placing a mark next to **"accepted"** in the last statement of this form.*

We hope that these instructions will be beneficial in helping our patients complete this form. If you have any questions, please call 480-488-8020. Thank you for your assistance in this effort.

edicine
Internal Medicine

PATIENT COMPLAINT FORM

Date: _____
Complainant Name:_____ Patient Name: _____
Address:_____
Birth date or SSN: _____
Personal Representative: _____ Relationship: _____
Telephone: (Day) _____ (Evening) _____
What is the best way to reach you? _____

Describe your complaint as specifically as possible: _____
_____
_____
Please include names of employees or providers involved: _____
_____
Date on which the occurrence happened:_____

_____ _____
Signature Date

FOR OFFICE USE ONLY: Review of complaint

Complaint Reviewed by:_____ Title: _____
Date: _____

Action Taken: _____
_____
_____
_____

Resolution: _____
_____
_____
_____

Date of Follow-Up with Involved Employee(s): _____

Follow-Up Action: _____
_____

Individual making complaint notified that complaint will be evaluated by _____ on: _____.

Privacy/Compliance Officer Signature: _____ Date: _____