

# Authorization to Release Medical Records

I hereby authorize:

<b>Practice Name:</b>	<b>Doctor Name:</b>
<b>Address:</b>	<b>City, State, Zip:</b>
<b>Phone Number:</b>	<b>FAX Number:</b>

To release medical records and data pertaining to:

<b>Patient Name:</b>	<b>Social Security:</b>
<b>Date of Birth:</b>	<b>Phone Number:</b>
<b>Street Address:</b>	<b>City, State, Zip Code:</b>

*Please specify what records should be released:*

- All records
- All records between the dates of \_\_\_\_\_ and \_\_\_\_\_.
- Records pertaining to \_\_\_\_\_

*Release records to:*

**Vladimir Troche, M.D.**  
**17612 N. 59<sup>th</sup> Avenue, Suite 100**  
**Glendale, AZ 85308**  
**(602) 993-8636**  
**FAX # (602) 993-2528**

I understand that I may revoke this authorization at anytime, except to the extent that action based on this authorization has already been taken. This consent will expire six (6) months from the date on which it is signed.

Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Internal use only:*

Completed By: \_\_\_\_\_  
Date Records Mailed/Picked-up: \_\_\_\_\_