REQUEST FOR MEDICAL RECORDS

Patient Name: _____Date of Birth: _____

Address: _____ Phone No.: _____

_____

Dates of Treatment _____

Purpose of Disclosure _____

I authorize the release of records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease-related information, information relating to mental health and/or alcohol/drug use, contained in my file.

_____ All Medical Records
_____ History & Physical
_____ Hospital Information
_____ Laboratory Reports
_____ X-ray Records/Films
_____ Other: Please Specify: _____

I hereby authorize: _____
_____
_____

To release all of the above requested information relative to my treatment and care to:

Jeffrey R. LeSueur, M.D., P.C.
5448 S. White Mountain Rd., Suite 140
Lakeside, AZ 85929
Phone (928) 532-0072/Fax (928) 532-0078

Signature of Patient: _____Date: _____

Witness: _____Date: _____