Medical Records Release Form
We are a Healthcare Provider – DO NOT BILL

Please complete the following information:

Patient Name:_____ Date of Birth:_____

Address:_____

City, State & Zip Code:_____ Phone:_____ Cell or Alternate:_____

I authorize information to be sent to:

Del Sol Research Management, LLC

_____
(Requesting Physician Name)

_____
(Patient's Physician Name/Facility)

ATTENTION: _____

6369 E Tanque Verde Rd, Suite 200
Tucson, Arizona 85715
Phone: 520-257-3881
Fax: 520-844-1110

Indicate type of information to be released:

- ❑General Records-excluding protected records
- ❑ Laboratory/Pathology Records
- ❑ Pharmacy/Prescription records
- ❑ X-Ray/Radiology records
- ❑ Other-Specify:

_____
_____
_____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this**

These records are for services provided on the following dates:

_____

By signing this form, you are authorizing the use of disclosure of your protected health information as described above. This information may no longer be protected by federal privacy laws if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke this authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 1 year from the date of signing. Your refusal to sign will not affect the ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with exception of obtaining information in connection with eligibility or enrollment in a health plan

_____ _____ _____
Signature of Patient or Legally Responsible Person | Relationship to Patient | Date

*A copy of this signed authorization must be given to the individual
This return request requires a minimum of 48 business hours