10565 N 114th Street, Suite 103
Scottsdale, AZ 85259
Phone: (480) 621-3505

JULIE LONGMIRE, NP-C
TRACIE HARRIS, NP-C
STEPHANIE NIEPOKOJ-DUNN, NP-C

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____

Name of physician/facility: _____

Address: _____

Phone: _____ Fax: _____

I hereby authorize and request my health information to include:

- All office visit notes from the last two years
- All laboratory results from the last two years
- All specialist notes from the last two years
- The most recent mammogram (if applicable)
- The most recent DEXA scan (if applicable)
- The most recent Pap smear (if applicable)
- The most recent colonoscopy (if applicable)
- The most recent diabetic eye exam (if applicable)

These records are requested for continuity of care. Please fax records to 480-621-3506, mail or send via secure electronic delivery if available.

Please do not fax more than 50 pages. Large records please mail to the address above.

This request will expire one year from the date of signing unless otherwise specified.
I understand that I may revoke this authorization at any time by contacting the facility listed above.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

Signature: _____ Date: _____