Performance Medicine Institute
3330 N 2nd St Ste 401 | Phoenix, AZ 85012
602-606-8949 call/text | 602-759-7409 fax
info@PerformanceMedInst.com
www.PerformanceMedInst.com

Medical Records Release or Request

I, the undersigned below, authorize the Performance Medicine Institute (PMI) to disclose the information described below to the recipients described below, or obtain the information described below from the source described below. If records are sent via mail, the patient acknowledges that records will be sent via first class USPS mail. I agree to the statements and information contained in this authorization.

PATIENT INFORMATION		
Patient Name	Other Names During Treatment	Date of Birth
Patient Address		Phone

RELEASE INFORMATION	
Please check one: ☐ Release Information To ☐ Release Information From	
Name/Facility/Provider	Attention
Address	Phone
Purpose of Request ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability ☐ Military/VA ☐ Other	Fax

Release of Protected Information

Please check the boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records:

I ☐ Do ☐ Do Not want information on mental health to be released.
I ☐ Do ☐ Do Not want information on HIV testing to be released.
I ☐ Do ☐ Do Not want information about sexually transmitted diseases to be released.
I ☐ Do ☐ Do Not want information on alcohol and/or substance abuse to be released.

FEES

For requests to send your records to another healthcare provider, there will be no fee.
For other purposes, there is a $20.00 handling fee plus an additional $0.25 per page after the first five printed pages.

INFORMATION TO BE RELEASED

Please provide my medical records in this date range From: To:

FORM OF OUTBOUND RECORDS RELEASE

☐ Print records to pick up ☐ Print records and mail to address above ☐ Fax records to number above

☐ Records to be sent via e-mail, provide e-mail address: _____

FORM OF INBOUND RECORDS RELEASE

☐ Mail records to: Performance Medicine Institute, 3330 N 2nd St Suite 401, Phoenix, AZ 85012
☐ Fax records to: Performance Medicine Institute, 602-606-8949 ☐ E-mail records to: records@performancemedinst.com

AUTHORIZATION

Please allow up to 30 days to process this request. This authorization will expire 12 months from the date it is signed. I understand that I may revoke this authorization at any time by notifying PMI in writing to: 3330 N 2nd St Suite 401, Phoenix, AZ 85012. If I do revoke this authorization, the revocation will not have any effect on the actions PMI took before the revocation was received. I also understand that under applicable law the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard. PMI may not condition treatment, payment, enrollment, or eligibility for benefits based on where I sign this authorization. I also understand that I may inspect or copy the information that is used or disclosed.

Patient or Parent/Representative Signature	Date
If Parent or Representative, state name of Parent or Representative and relationship to Patient	