City of
Casa Grande

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, hereby request and authorize the City of Casa Grande to release all pertinent medical records, including lab and test results, in the possession of the City of Casa Grande to the person(s) listed below. This release authorization applies to all medical records, as well as any other information, governed by any federal, state, and local law, rule, or regulation (including but not limited to HIPAA and Arizona Revised Statutes.)

Person(s) to whom the release of medical records is authorized:

_____

_____

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Patient's Soc. Sec # or I.D # Patient's Signature

_____

Today's Date

State of _____

} Ss

County of _____

Subscribed and sworn to before me this _____ day of _____ 2017.

Notary Signature: _____

Notary Seal

Telephone: (520) 421-8600 - Telefacsimile: (520) 421-8602
Administration: 510 East Florence Boulevard - Casa Grande, Arizona 85122