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(P): 623-321-5079 ||
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zonaspine.com

Personal Records Requests

Prior to receiving copies of your medical records, you must completely fill out the Personal Records Request form below. Completed forms may be drop off, mailed, or faxed to our office. Please allow up to two weeks to process your request.

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____
City, State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Information Being Requested

❑Specific Records/Dates of Service: _____
❑All Records

REASON FOR RECORDS REQUEST: ❑Self ❑Continuing Care ❑Other (Specify): _____

- There may be a fee associated with you records request.
- There is no charge for doctor-to-doctor requests and transfer of records to other providers.
- We will not provide records from other providers outside of Zona Spine and Pain. Please request these records directly from those providers.

Delivery Method

❑ Pick up at office
❑ Mail to address (postage charges will apply): _____
❑ Fax to: _____
❑ If someone other than the above-mentioned patient is picking up the records, please specify their name and relationship:
Full Name of individual to release records to: _____ Relationship: _____

- I understand that I may revoke this authorization at any time with written notification provided to Zona Spine and Pain. The revocation will not apply to information that has already been released in response to this authorization. Otherwise, the authorization will expire two years from the date of signature below.
- I understand the health information authorized to be released in this form may include information related to alcohol abuse, drug abuse, psychiatric status, testing results, HIV status and other sensitive information.
- I understand that a copy of this signed form will be considered as effective and valid as the original.
- I understand that signing this authorization is voluntary and I can refuse to sign this authorization.

Patient's Signature: _____ Date: _____