Print Form

A. Daniel Greco, M.D., FACS
Diplomate American Board of Surgery

General Surgery and Endoscopy

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name _____ **DOB** _____

Address _____ Home Phone _____

_____ Other Phone _____

Requesting Records From _____

Address _____

_____

_____

Phone _____ Fax _____

Please release all medical records unless specified below:

_____

Reason for requesting records _____

I authorize the release of the above requested records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease information, confidential information related to mental health, drug and/or alcohol use, or sexual history.

I further authorize that these records may be faxed.

I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorized has already been taken. I have given my consent freely, voluntarily and without coercion.

_____ _____ _____

Patient Signature (or parent/legal guardian) Relationship to patient Date

Please mail or fax records to:

A. Daniel Greco, M.D.
PO Box 2260
Lakeside, AZ 85929
Phone 928-532-5463
Fax 844-682-5976