Record Release Form
Pierpont Family Medicine
(Full Circle Health)
4838 E Baseline #103
Mesa, AZ 85206
Voice: 480-926-8000 Fax: 480-926-3445

I ____________________________________________ authorize
Patient's Name PLEASE PRINT

____________________________________________
Name of Person being Authorized PLEASE PRINT

to received and/or review all medical records, documentation, billing, and any/all other records maintained by Pierpont Family Medicine (Full Circle Health) regarding myself.

I understand that I can change this authorization at any time by signing the bottom portion of this form.

Date: ____________

Patient's Signature: ____________________________________________

Revoke Record Release Form
I ____________________________________________ REVOKE authorization for
Patient's Name PLEASE PRINT

____________________________________________
Name of Person being Authorized PLEASE PRINT

to received and/or review all medical records, documentation, billing, and any/all other records maintained by Pierpont Family Medicine regarding myself.

I understand that I can change this authorization at any time by resigning the above portion of this form.

Date: ____________

Patient's Signature: ____________________________________________