



**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION**

PATIENT INFORMATION

Patient Name _____ Birth Date _____
 Address _____
 City _____ State _____ Zip _____

INFORMATION TO BE RELEASED FROM

Name of Physician/Organization _____	Address _____	Fax / Phone _____
_____	_____	_____

INFORMATION TO BE RELEASED TO

Name of Physician/Organization _____	Address _____	Fax / Phone _____
_____	_____	_____

PURPOSE OR NEED FOR THIS INFORMATION (Please check a box)

- Moving Specialist Appt. Dissatisfaction Change of Insurance Plans
 Other (specify) _____

TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked)

General Release

- Medical Records/Excluding Protected Records
 (this will be limited to 1 year of information including Lab, x-ray reports
 unless otherwise stated)
 Other Records (specify) _____

DATES OF TREATMENT

From _____ To _____
 From _____ To _____
 From _____ To _____

Information Protected by State/Federal Law

- All of my records including:
 AIDS/HIV and other communicable disease information,
 behavioral health/psychiatric care, alcohol and/or
 drug abuse treatment

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understand that it is prohibited from making any disclosure of this information unless further disclose is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Arizona Community Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. **I authorize Arizona Community Physicians to use and disclose the protected health information specified above.**

 Signature of Patient OR Legal Representative

 Date

 Please Print Name of signing party

**If this request is made by mail, this office
 may require the request be notarized by a
 State Notary Public.**

Patient Requesting Medical Records Copy
 The charge for copying medical record will be \$2.00
 for the first page and .25 for each additional page.