



1925 W. Orange Grove Road, Suite 207  
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[www.azacp.com](http://www.azacp.com)

## **Aria Internal and Family Medicine**

*An Affiliate of Arizona Community Physicians*

Thank you for your interest in becoming a new patient at Aria Internal and Family Medicine. To provide safe, focused primary care, and in accordance with Arizona prescription monitoring requirements, Dr. Sparkes has established the following policies for all new patients:

Dr. Sparkes does not initiate or continue long-term prescriptions for opioids, benzodiazepines, stimulants, sedatives, or testosterone. This includes narcotic pain medications, anxiety or sleep medications, ADHD stimulants, and testosterone therapy.

Patients who require ongoing management of these medications will be referred to appropriate specialists, including pain management or psychiatry, as clinically indicated. Our practice focuses on general medical care and chronic disease management.

In addition, Dr. Sparkes does not complete disability determination forms (including short-term, long-term, or permanent disability paperwork). Patients requiring disability evaluation or documentation will need to work with the appropriate specialist or a designated disability assessment provider.

If you are currently followed by pain management, psychiatry, or another specialist, please provide their contact information so we may coordinate care as needed.

Please understand that these policies are firm. Thank you for your understanding and cooperation.

Sincerely,

**Stephanie Sparkes, M.D.**

### **Acknowledgment**

By signing below, I acknowledge that I have read, understand, and agree to the policies outlined above.

Patient Name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

## Office Policies and Procedures

Our providers and staff members are trained to assist you in obtaining the best care possible, and to do so with courtesy and compassion. We strive to provide the best professional care possible. In turn, we expect our patients to treat our staff with courtesy and respect. Disrespectful or aggressive behavior towards our staff and providers will not be tolerated and will result in the termination of your care at **ARIA Internal Medicine**.

1. All patients should arrive for appointments at their appointed check-in times. This policy is in place so the necessary intake efforts can be made and so that you can be roomed in a timely manner. Patients who arrive late create an inconvenience for our providers as well as other patients. Our practitioners reserve the right to ask you to reschedule if you are late. Please do not wear perfume or cologne as a courtesy to other patients that have fragrance sensitivities.
2. If there is a need to cancel your appointment, please do so at least 24 hours in advance. There is a \$50.00 fee if you do not show for your appointment or if you do not give 24 hours' notice when canceling an appointment. There is a cancellation line for after hour needs. Please remember, reminder calls are a courtesy, not mandatory. If you do not show up to your scheduled appointment and do not cancel it in advance, we reserve the right to release you from our practice.
3. Co-pays and deductibles are due at the time of service as dictated by your insurance. We do not bill co-pays. We will accept cash, check, Visa, Mastercard, Discover and American Express. You will also be asked to present your insurance card at each visit.
4. To assist us in providing optimal medical care, please bring in an updated list of medications, including the strength and directions, to each visit. If we are managing your diabetes or hypertension, please bring in your glucose and/or blood pressure readings.
5. Nurse visits for lab draws and injections are generally scheduled between 7:30AM-10:45AM and 1:30PM-3:15PM. An appointment is necessary.
6. Please provide us with at least two phone numbers that we can contact you at regarding your healthcare. If you use a PO Box, please provide us with a physical address to use only in the event of an emergency.
7. Insurance/FMLA paperwork usually requires an office visit to fill them out. There will be a \$50.00 charge for filling out these forms whether or not an appointment is needed. The price is based on the amount of time required to complete the forms. This fee may be increased for extensive letters and reports. Please allow up to 10 days to complete forms. An additional \$50.00 will be charged if forms are requested to be "Expedited" (five days or less turnaround time). There is no charge for filling out MVD handicap forms.
8. Please allow 72 hours for refills on prescriptions. Our on-call doctors will not send in controlled medications – opioids, benzos, etc. If you are in need of such a prescription after hours or on the weekend, you will be referred to the emergency room. Please call your pharmacy for routine refills of medications.
9. Referrals may take up to 14 days depending on your insurance carrier. Some procedures require a prior-authorization, delaying the completion of your referral.

Signature of Patient/Legal Representative

Date

# Arizona Community Physicians

## Patient Information

FIRST NAME	MIDDLE	LAST NAME	ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE		EMERGENCY PHONE#	EMERGENCY CONTACT NAME / RELATION		
/ /						
DOB	SEX	MARITAL STATUS		EMAIL	RACE (optional)	

PRIMARY CARE PHYSICIAN	STUDENT? FT OR PT	PREVIOUS NAME
------------------------	-------------------	---------------

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE
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### **Billing Information**

**(If different than patient)**

FIRST NAME	MI	LAST NAME	ADDRESS	CITY	STATE/ZIP	PHONE
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### **Primary Insurance Information**

INSURANCE NAME	EFFECTIVE DATE	MEDICAL CLAIMS ADDRESS
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GROUP ID#	POLICY ID#	SELF      SPOUSE      CHILD      OTHER
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SUBSCRIBER NAME (POLICY HOLDER)	SUBSCRIBER ADDRESS (if different than patient)	SUBSCRIBER PHONE (if different than patient)
---------------------------------	--	--

SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX	SUBSCRIBER SSN#	CO-PAY AMOUNT
--------------------------	----------------	-----------------	---------------

SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE#
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### **Secondary Insurance Information**

INSURANCE NAME	EFFECTIVE DATE	MEDICAL CLAIMS ADDRESS
----------------	----------------	------------------------

GROUP ID#	POLICY ID#	SELF      SPOUSE      CHILD      OTHER
-----------	------------	--

SUBSCRIBER NAME (POLICY HOLDER)	SUBSCRIBER ADDRESS (if different than patient)	SUBSCRIBER PHONE (if different than patient)
---------------------------------	--	--

SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SEX	SUBSCRIBER SSN#	CO-PAY AMOUNT
--------------------------	----------------	-----------------	---------------

SUBSCRIBER EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE#
---------------------	------------------	-----------------

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

*The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.*

PERSON GIVING CONSENT	RELATIONSHIP IF NOT THE PATIENT	DATE
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# Patient Registration



Patient Name:

MRN:

Date of Birth:

Date:

*Please Circle Most Appropriate Response*

## Employment Status

Full Time      Part Time

Employer: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

Not Employed

Retired

Disabled

On Active Military Duty

Student – Full Time      Part Time

Unknown

## Veteran Status

No, Never Served

No, Currently Serving - Branch \_\_\_\_\_

Yes - Branch \_\_\_\_\_

Yes, Combat Veteran - Branch \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Best Contact Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Best Contact Phone Number: \_\_\_\_\_

## Marital Status

Married      Single

Divorced      Legally Separated

Widowed      Significant Other

Other

## Ethnicity

Cuban

Decline to Answer

Mexican, Mexican American, or Chicano/a

Not Hispanic, Latino/a, or Spanish origin

Other Hispanic, Latino/a, or Spanish origin

Puerto Rican

Unknown

## Race

American Indian or Alaska Native

Asian Indian

Black or African American

Chinese

Samoan

Filipino

Vietnamese

Guamanian or Charnorro

White

Japanese

Other

Korean

Unknown

Native Hawaiian

Decline to Answer

Other Asian

Other Pacific Islander

Email: \_\_\_\_\_

## MyChart

Do you want to sign up for MyChart - Yes      No

*Patient portal - access to your medical records*

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

MRN \_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Phone \_\_\_\_\_

**General Information:**

Date: \_\_\_\_\_

Gender: \_\_\_\_\_

How long have you lived in Arizona? \_\_\_\_\_ Where did you live before? \_\_\_\_\_

What is your occupation/former occupation? \_\_\_\_\_

Relationship Status:  Married/Partner  Single  Divorced  Widowed

Are you sexually active?  Yes  No Preferred Partner:  Male  Female  Both

Do you have any children?  Yes  No How many? \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Do you follow any type of diet, if yes what? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

If yes, how many drinks? \_\_\_\_\_ /day \_\_\_\_\_ /week \_\_\_\_\_ /month

Do you use tobacco?  Now  Past  Never

If so, what? \_\_\_\_\_ How much? \_\_\_\_\_ For how long & year quit? \_\_\_\_\_

Do you use illicit drugs?  Now  Past  Never

If so, what? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you use Cannabis?  Now  Past  Never

Do you vape?  Now  Past  Never

**Over the past two weeks have you felt (check the answer that applies the most to you):**

Little interest or pleasure in doing things?	<input type="checkbox"/> No days (0)	<input type="checkbox"/> Several days (1)	<input type="checkbox"/> More than half the days (2)	<input type="checkbox"/> Nearly every day (3)
Feeling down, depressed, or hopeless?	<input type="checkbox"/> No days (0)	<input type="checkbox"/> Several days (1)	<input type="checkbox"/> More than half the days (2)	<input type="checkbox"/> Nearly every day (3)

MRN \_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Phone \_\_\_\_\_

### **Allergies / Adverse Reactions to Medications and/or Products**

What	Reaction

### Medications and Supplements



MRN \_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Phone \_\_\_\_\_

## Self/Family History

Adopted \_\_\_\_\_ Unknown family history: \_\_\_\_\_

## **Surgical History**

## Specialists You See

MRN \_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Phone \_\_\_\_\_

### **Health Maintenance/Prevention**

Please check if you have received the following and when they were received:

<input type="checkbox"/> Influenza	Date: _____	<input type="checkbox"/> HPV/Gardasil	Date: _____
<input type="checkbox"/> Tetanus (Td/Tdap)	Date: _____	<input type="checkbox"/> Prevnar 13	Date: _____
<input type="checkbox"/> Hepatitis A	Date: _____	<input type="checkbox"/> Pneumococcal	Date: _____
<input type="checkbox"/> Hepatitis B	Date: _____	<input type="checkbox"/> Shingles	Date: _____
<input type="checkbox"/> Varicella	Date: _____		
<input type="checkbox"/> Covid	Date: _____		
<input type="checkbox"/> RSV	Date: _____		

### **Screenings**

<input type="checkbox"/> Eye exam	Date: _____	<input type="checkbox"/> Pap smear	Date: _____
<input type="checkbox"/> Dental exam	Date: _____	<input type="checkbox"/> Hepatitis C test	Date: _____
<input type="checkbox"/> Mammogram	Date: _____	<input type="checkbox"/> HIV test	Date: _____
<input type="checkbox"/> DEXA	Date: _____	<input type="checkbox"/> PSA test	Date: _____
<input type="checkbox"/> Colon cancer screening (circle type): <input type="checkbox"/> iFOBT <input type="checkbox"/> Cologuard <input type="checkbox"/> Colonoscopy			
Date last done: _____			

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

Date: \_\_\_\_\_  
MRN: \_\_\_\_\_

## Review of Systems

### Constitutional (affecting general well being)

- No symptoms
- Activity change
- Appetite change
- Chills
- Diaphoresis (unusual perspiration/sweating)
- Fatigue
- Fever
- Unexpected weight change

### Respiratory

- No symptoms
- Apnea
- Chest tightness
- Choking
- Cough
- Shortness of breath
- Stridor (high-pitched/musical breathing sound)
- Wheezing

### Hent (Head, Ears, Nose, Throat)

- No symptoms
- Congestion
- Dental problem
- Drooling
- Ear discharge
- Ear pain
- Facial swelling
- Hearing loss
- Mouth sores
- Nosebleeds
- Postnasal drip
- Rhinorrhea (runny nose)
- Sinus pain
- Sneezing
- Sore throat
- Tinnitus (ringing in the ears)
- Trouble swallowing
- Voice change

### Cardio

- No symptoms
- Chest pain
- Leg swelling
- Palpitations

### Gastroenterology

- No symptoms
- Abdominal distention
- Abdominal pain
- Anal bleeding
- Blood in stool
- Constipation
- Diarrhea
- Nausea
- Rectal pain
- Vomiting

### Eyes

- No symptoms
- Eye itching
- Eye pain
- Eye redness
- Photophobia (painful oversensitivity to light)
- Visual disturbance

### Endocrine

- No symptoms
- Cold intolerance
- Heat intolerance
- Polydipsia (extreme thirstiness)
- Polyphagia (excessive appetite/eating)
- Polyuria (excessive urination)

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

Date: \_\_\_\_\_  
MRN: \_\_\_\_\_

## Review of Systems

### GU (Genitourinary)

- No symptoms
- Difficulty urinating
- Dyspareunia (painful intercourse)
- Dysuria (pain, discomfort or burning with urination)
- Enuresis (involuntary urinary incontinence)
- Flank pain
- Frequency
- Genital sore
- Hematuria (blood in urine)
- Menstrual problem
- Pelvic pain
- Urgency
- Urine decreased
- Vaginal bleeding
- Vaginal discharge
- Vaginal pain

### Musculoskeletal

- No symptoms
- Arthralgias (joint pain/stiffness)
- Back pain
- Gait problem (walking balance/coordination)
- Joint swelling
- Myalgias (muscle pain)
- Neck pain
- Neck stiffness

### Skin

- No symptoms
- Color change
- Pallor (pale color of skin)
- Rash
- Wound

### Allergy/Immunologic

- No symptoms
- Environmental allergies
- Food allergies
- Immunocompromised

### Neurological

- No symptoms
- Dizziness
- Facial asymmetry
- Headaches
- Light-headedness
- Numbness
- Seizures
- Speech difficulty
- Syncope (fainting or passing out)
- Tremors
- Weakness

### Hematologic

- No symptoms
- Adenopathy (enlargement of lymph nodes)
- Bruises/bleeds easily

### Psychiatric

- No symptoms
- Agitation
- Behavior problem
- Confusion
- Decreased concentration
- Dysphoric mood (feeling uneasy)
- Hallucinations
- Hyperactive
- Nervous/anxious
- Self-injury
- Sleep disturbance
- Suicidal ideas

# Aria Internal Medicine

Arizona Community Physicians, P.C.

## Release of Information Form

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ MRN \_\_\_\_\_  
Date \_\_\_\_\_

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship \_\_\_\_\_ Contact Number \_\_\_\_\_

→ By providing the below phone number(s) you are giving permission to leave voicemails regarding appointment information and/or detailed health information (i.e. lab results, radiology results or any other imperative information regarding your health).

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

**DO NOT RELEASE** Information to the following people: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that either I or the physician may withdraw the releasing of test information at any time, upon written notice. Any questions I had have been answered.

→ **SIGNATURE OF THE PATIENT/LEGAL GUARDIAN** \_\_\_\_\_

The information provided on this form will stay in effect until updated by the patient

Form 116-Adult 18+  
Revised 11/28/18

Arizona Community Physicians  
5055 E. Broadway, Suite A-100  
Tucson, AZ 85711  
520-327-0460

**HIPAA**

**NOTICE OF PRIVACY PRACTICES**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact Arizona Community Physicians Business Office by mail or phone. Our contact information is listed above.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices is **NOT** an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**TREATMENT**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

**PAYMENT**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**HEALTHCARE OPERATIONS**

We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

*Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.*

Arizona Community Physicians  
5055 E. Broadway, Suite A-100  
Tucson, AZ 85711  
520-327-0460

#### **USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

#### **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information:

**You have the right to inspect and have a copy of your protected health information (fees may apply)**. Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**Patient Requesting Medical Record Copies**. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.

**You have the right to request a restriction of your protected health information** – You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**You have the right to request to receive confidential communications** – You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

**You have the right to request an amendment to your protected health information** – You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

**You have the right to receive an accounting of certain disclosures** — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

**You have the right to receive notice of a breach** - We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Relationship (if not patient): \_\_\_\_\_

Date: \_\_\_\_\_



## Arizona Community Physicians P.C. Authorization to Release Medical Information

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ Former Name \_\_\_\_\_ Account # \_\_\_\_\_  
Daytime Telephone \_\_\_\_\_ Birth Date \_\_\_\_\_

### INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) \_\_\_\_\_  
Street Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax# \_\_\_\_\_  
To release the following medical information contained in patient's medical record.

### INFORMATION TO BE RELEASED TO

Name of Physician/Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax# \_\_\_\_\_  
Requested format  Paper  Disc (PDF format)  Email\*

\*Email option only available for medical records processed by CIOX.  
PURPOSE FOR THIS REQUEST (Please check a box)

At request of Patient  Other\* (specify) \_\_\_\_\_

\*The standard charge for copying medical records is \$6.50 for a disc and \$0.07 per page for paper. However, there may be additional charges for shipping and handling. Please do not submit payment with this request, you will receive a billing invoice.

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

#### General Release

Medical Records/Excluding Protected Records DATES OF TREATMENT  
(This will be limited to 1 year of information including Lab, x-ray reports From \_\_\_\_\_ To \_\_\_\_\_  
unless otherwise stated)

Other Records (specify) \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

#### Information Protected by State/Federal Law

All of my records including: From \_\_\_\_\_ To \_\_\_\_\_  
AIDS/HIV and Other Communicable Disease Information,  
Behavioral Health Care/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.

**Signature of Patient or Personal Representative who may request Release of Medical Information:** I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of Patient OR Legal Representative Date

Please Print Name of Signing Party