



Arizona Community Physicians P.C. Authorization to Disclose 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# _____

PURPOSE FOR THIS REQUEST (Please check a box)

- Moving Treatment or consultation Dissatisfaction Change of Insurance Plans At patients request
 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)

DATES OF TREATMENT

From _____ To _____

Other Records (specify) _____

From _____ To _____

Information Protected by State/Federal Law

All of my records including:
AIDS/HIV and Other Communicable Disease Information,
Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

From _____ To _____

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 understands that it is prohibited from making any disclosure of this information unless further disclosure 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 or disclose the protected health information as specified above.**

Signature of Patient OR Legal Representative

Date

Please Print Name of signing party

Patient Requesting Medical Record Copies

The standard charge for copying medical records is \$6.50 for a disc and \$0.07 per page for paper. However there maybe additional charges for shipping and handling.

FORM # 100
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