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

☐ ACP Northwest Imaging
2191 W Orange Grove Rd.
Tucson, AZ 85741
Phone: (520) 547-3940

☐ ACP Eastside Imaging
5515 East 5th Street
Tucson, AZ 85711
Phone: (520) 298-1138

INFORMATION TO BE RELEASED TO

Name of Physician/Organization/Individual____

Street Address ____

City/State/Zip____

Phone # ___________________________________Fax#____

Requested format: ☐ Paper (Reports Only) ☐ Disc (Reports and Images)

Delivery method: ☐ Mailed to address listed above. ☐ Pickup at selected imaging location.

PURPOSE FOR THIS REQUEST **(Please check a box)**

☐ At request of Patient ☐ Continuity of care (requested by another provider)

*__The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper may apply. However, there may be additional charges for shipping and handling.__

TYPE OF INFORMATION TO BE RELEASED (Box must be checked and information provided)

☐ Specific images and reports
(Prior studies/ Todays exam(s))

1. ____ Date__________
2. ____ Date__________
3. ____ Date__________
4. ____ Date__________

General Imaging Release

☐ All study images and reports (requesting multiple dates of service)
(This will be limited to 1 year of information unless otherwise indicated)

DATES OF 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.

Signature of Patient or Personal Representative who may request Release of Medical Information: I hereby authorize the release of the above indicated 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**

MR use only Date request received___/___/___ Date request completed ___/___/____ Completed by ___________

Form 100-Authorization to Release Medical Records (Imaging specific)
Revised: 9/28/2022