Arizona Community Physicians P.C.
Authorization to Disclose Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____ Birth Date_____

Would you like these records to be in ☐ **Paper** form or ☐ **Disc** form (**Please check a box**)

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

Street Address _____

City/State/Zip_____

Phone # _____

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 # _____

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 DATES OF TREATMENT

☐Medical Records/**Excluding Protected Records**

(This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) From_____ To_____

☐ 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.

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 and disclose the protected health information 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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