

**ARIZONA COMMUNITY PHYSICIANS, P.C.**  
**AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION**

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Account # \_\_\_\_\_  
Former Name (If any) \_\_\_\_\_  
Daytime Telephone \_\_\_\_\_ Birth Date \_\_\_\_\_

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) \_\_\_\_\_  
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 THE 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:  
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 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 charge for copying medical records from a paper chart will be \$0.50 a page.  
For offices using our Electronic Health Record system, patients may request a  
copy of their chart on a "CD" for \$10.00