CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

3638 E. Southern Ave. Ste C108 | Mesa, Arizona 85206 | Phone 480-834-0771 | Fax 480-834-1136

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Street _____ Bldg/Apartment/Lot _____

City _____ State _____ Zip Code _____

Phone _____

Authorization Information *Select one (1) of the authorization options below*

I hereby authorize Central Arizona Medical Associates to take the following action:

[ ] Provide my health information to me

[ ] **Release** my health information to the Healthcare Provider or Facility below

[ ] **Obtain** my health information from the Healthcare Provider or Facility below

Please complete entirely

Full name of Healthcare Provider or Facility _____

Street _____ Bldg/Suite _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Purpose Of Disclosure

☐ Transfer of care ☐ Personal use ☐ Legal ☐ Other *must specify* _____

Health Information To Be Disclosed

☐ Last _____ month(s) ☐ Last _____ year(s) ☐ Entire record

☐ Specific records _____

Optional [ ] Check here to authorize the release of subsequent records after the date of signature below.

Optional [ ] Check here to **EXCLUDE** the following types of records _____

Acknowledgment Of Understanding | Expiration Date | Signature

My signature below authorizes Central Arizona Medical Associates to release or obtain medical records as specified above and that I understand the following:

- **Unless excluded above, this authorization covers records relating to communicable diseases, AIDS, HIV, behavioral and/or mental health care (excluding psychotherapy notes), substance abuse and/or addiction treatment, and genetic testing, if any such records exist.**
- Central Arizona Medical Associates will not condition or deny treatment on whether I sign this authorization.
- I have the right to revoke this authorization at any time except that the revocation will not apply to information that has already been released in response to this authorization. In order to revoke this authorization, I must do so in writing and present my written revocation to the office of Central Arizona Medical Associates.
- If this information is disclosed to a third party, the information may no longer be protected by state, or federal regulations and may be re-disclosed by the person or organization that receives the information.
- I may request a copy of this authorization.
- I may be charged a reasonable fee in accordance with state law.
- This authorization will expire (1) year from the date of signing unless an earlier date is specified here _____

_____ _____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE - **Required** DATE - **Required**

_____ _____

Printed name of Authorized Representative - **Required if not Patient** Authorized Role for Patient - **Required if not Patient**

Please attach proof of your authority to act on behalf of the Patient (other than custodial parent)