# CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

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## AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Street _____ Bldg/Apartment/Lot _____

City _____ State _____ Zip Code _____

Phone _____

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

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

[ ] **OBTAIN** my health information from the Healthcare Provider or Facility or Individual listed below

[ ] **RELEASE** my health information to the Healthcare Provider or Facility or Individual listed below

[ ] Provide my health information to me

*Please complete entirely*

Full name of Healthcare Provider or Facility or Individual _____

Street _____ Bldg/Suite _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

### 2 Purpose Of Disclosure

☐ Medical treatment purposes ☐ Transfer of care ☐ Personal ☐ Legal ☐ Other *must specify*_____

### 3 Health Information To Be Disclosed *Select ONE (1)*

☐ Specific Records *must specify*_____

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

*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 _____

### 4 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 one (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**

*If not already an file, please attach proof of your authority to act on behalf of the Patient (other than custodial parent)*

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***FOR OFFICE USE ONLY: Received by:*** _____ ***Date:*** _____ ***Processed by:*** _____ ***Date:*** _____