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 patient's 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** Duane Dyson **MD 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 $0.10 a page.
For offices using our Electronic Health Record system, patients may request a copy of their chart on a "CD" for $10.00.