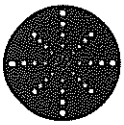
Authorization to Disclose Health Information



arizona institute *of* urology

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5670 N. Professional Park Drive, Tucson, AZ 85704
395 N. Silverbell Road, Suite 315, Tucson, AZ 85745
6565 E. Carondelet Drive, Suite 285, Tucson, AZ 85710
516 E. Whitehouse Canyon Road, Suite160, Green Valley, AZ 85614

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone#: _____

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 # _____

Information to be Released

1. There will be a $24 flat fee for all requests. There will be an additional $0.25/page fee for pages 51 and above. (See cover page for details)

2. Please provide information in my medical record for dates:
   From _____ To _____

3. Please check the boxes to the right for information being requested.

- ☐ Complete Health Record
- ☐ History and Physical Examination
- ☐ Office Visit Notes
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-Rays/Imaging Reports

Authorization to Release Protected

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check one		*Initial each line below*
I ☐ DO	☐ DO NOT	want information about ***Mental Health released**	_____
I ☐ DO	☐ DO NOT	want information about ***HIV Tests & Related Information released**	_____
I ☐ DO	☐ DO NOT	want information about ***Alcohol and/or Substance Abuse released**	_____
I ☐ DO	☐ DO NOT	want information about ***Communicable Diseases released**	_____

STOP

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature _____ **Date:** _____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Arizona Institute of Urology and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*