

Authorization to Disclosure Health Information



I, the undersigned, authorize

Arizona Urology, 13555 W. McDowell St., Suite 203, Goodyear, AZ 85395
 18555 N. 79th Ave., Suite E105, Glendale, AZ 85308

(623) 512-4390

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____
 Patient Address: _____ Date of Birth: _____
 City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____
 Address: _____ Phone: _____
 City: _____ State _____ Zip: _____ Fax: _____
 Purpose of Request: Personal Treatment Legal Insurance Disability
 Transfer/Reason _____ Other _____

Information to be Released

1. There will be a \$15 flat fee as well as a \$.25 per page fee for all requests. (See reverse for projected costs). Complete Health Record

2. Please provide information in my medical record for dates: History and Physical Examination
 From _____ To _____ Office Visit Notes

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

4. Please see reverse for payment. 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 _____



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 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.

Payment Information

- For cost **details, see 'Information to be Released' section on front of this form.**
- Please allow 2 to 5 business days for process of payment.

Credit Card / Debit Card:

Name on Card: _____

Credit Card #: _____

Card Expires: _____

*Arizona Urology utilizes BACTES IMAGING SOLUTIONS, a trusted outsourced vendor to complete medical records requests. Please allow 10 to 14 days for your medical records to be securely delivered via United States Postal Service.

Type of Card (Please Check One):

- Visa
- Mastercard
- Discover
- American Express

Billing Address:

Street: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

*For a typical 2 Year Abstract- Office Notes, Labs, X-Rays, ect. (EXAMPLE):

Flat Processing Charge:		\$15.00
Per Page Fee (\$.25/page):	30 Pages	\$7.50
Total:		\$22.50

*Please note - request will not be processed until payment is received.

"We treat every medical record as if it were our own."

