ARIZONA DIABETES & ENDOCRINOLOGY, PLC

3489 S. Mercy Road, Suite 101, Gilbert, AZ 85297 Phone (480) 646-8433 Fax (480) 646-8434 www.azdne.com

Authorization for Release of Medical Information

Patient Name (Please Print):_____ Date of Birth:_____

X Obtain Information From **OR** □ Release Information To

Mark One Selection: Physician Facility Self Other

Name: _____Phone: _____ Fax: _____

Address: _____

Information to be Released:

□ Complete Records
□ Progress Notes
□ Lab/X-Ray Reports
□ Whole Body Scan
□ Billing Information
□ Biopsy/Pathology Report
□ Surgical Report
□ Other: _____

Information to be Restricted:

The patient restricts the release of the following:
□ Behavior & Mental Health Records
□ Communicable Diseases (including HIV/AIDS
□ Alcohol & Drug Abuse Treatment
□ Genetics □ Other

Form and Method of Release:

Records should be sent by □ Hard Copy/Paper □ Soft Copy/Electronic Format

□ Mail to address above X Fax to number above □ Notify patient to pick-up when ready
(Requests containing more than 30 pages must be picked up or mailed in electronic format)

Service Dates:

□ All Dates **OR** □ From_____ to_____

Purpose of Release:

□ Treatment/Continuity of Care
□ Transfer of Medical Care
□ Insurance Coverage
□ Disability Determination
□ Legal Purposes
□ Moving
□ Personal
□ Other: _____

This authorization will expire one (1) year from the date of signing, or as indicated here: _____and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity. I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.

Signature: _____ Date Signed: _____

Printed Name of Person Signing (if not patient): _____