

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: _____

Obtain Information From OR Release Information To

Mark One Selection: Physician Facility Self Other

Name: _____ Phone: _____ Fax: _____

Address: _____

Information to be Released:

- Complete Records Billing Information
 Progress Notes Biopsy/Pathology Report
 Lab/X-Ray Reports Surgical Report
 Whole Body Scan 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 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 Legal Purposes
 Transfer of Medical Care Moving
 Insurance Coverage Personal
 Disability Determination 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): _____