Patient Information (Please Print)

Patient Name ______ **Date of Birth** ______ **Social Security No.** ______ **Phone** ______

Address ______ **City/ST** ______ **Zip** ______

Release from (Name of physician or facility releasing information)
PREVIOUS PRIMARY CARE PROVIDER OR SPECIALIST

I authorize release of my medical records from:

______

Physician/facility

______ ______ ______

Address **City/ST** **Zip**

PLEASE SEND MEDICAL RECORDS TO: FAX: (928)344-4166 OR
Arizona Medical Center 2095 W 24TH ST. STE. A, YUMA, AZ. 85364

Release Information

Reason: ☐ Change of Insurance ☐ Transfer of care ☐ Special Consultation
☐ Personal File ☐ moving out of area ☐ Legal

Please release the following (check all that apply)

Recent H & P Hospital Reports X-Ray Reports
☐ Last three Visits Lab Reports Other: ______
All records for the last 12 months only

Consent

I authorize the release of photocopies of the following medical records and/or diagnostic images in the possession or control of Arizona Medical Center, its employees And/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" and "DIAGNOSTIC IMAGES" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV- RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE TREATMENT PROGRAM INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ).
4. CONFIDENTIAL PSYCHOTHERAPHY NOTES. (AS DEFINED IN 42 CFR SECTION 164.501).
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801).

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand it is possible that the information in my medical records may be disclosed by the recipient to other parties. This consent will expire ninety (90) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Arizona Medical Center in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Certain information concerning a minor is governed by AZ State and Federal statutes and will require the minor's signature prior to any release. I understand that a photocopy/facsimile of this authorization is considered acceptable in the lieu of the original.

______

Patient Signature: **Date:**

______ ______

Parent / Guardian / Power of attorney: Relationship to patient: **Witness/Notary** **Date:**

______ ______ ______ ______