Arizona State Urology

**Patient Identifying Information:**

Patient Name: _____ Date of Birth: _____

Address: _____City_____ State_____ Zip Code_____

Phone Number: _____ Date (s) of Service(s): _____

**Release of medical records to Arizona State Urology:**

I authorize _____ to release my medical records as I have indicated in **Section 2:**

**Disclose to: Arizona State Urology**

**Address: 6525 W. Sack Drive Suite 201 Glendale, AZ 85308**

**Phone: 602 337-8500 Fax: 602 337-8151**

2. **Specific Description of Information to Be Disclosed** (check all that apply):

☐ Discharge Summary, History and Physical Exam, Operative Reports, Consultation reports

☐ X-ray Reports, Pathology, Lab Testing, Progress Notes

☐ Pertinent Records Only Other (Specify)_____

Specific description of the purpose of disclosure:

☐ The disclosure is at the patient's request Other(Specify)_____

I authorize the provider to use or disclose information related to:

☐ AIDS/HIV ☐ Genetic Testing Information

☐ Psychiatric Care Reports ☐ Alcohol and/or Drug Abuse Treatment

I understand that Arizona State Urology, PC will not condition on my signing this authorization. Arizona State Urology, PC will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time with some exceptions. For more details on when I can or cannot revoke this authorization, I can read Arizona State Urology, PC Notice of Privacy Practices.

To revoke my authorization, I must submit written request to Arizona State Urology, PC. Unless I revoke the authorization earlier, it will expire upon its completion or 180 days from the date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulation and may be re-disclosed by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associated to the extent indicated and authorized herein.

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____