Patient Identifying Information:

Patient Name: ____ Date of Birth: _______________________________

Address: ____City______________ State___________ Zip Code_______

Phone Number: ______________________________ Date (s) of Service(s): _____________________________________

Release of medical records from Arizona State Urology:

I authorize ARIZONA STATE UROLOGY to release my medical records as I have indicated in **Section 2:**

Disclose to: ____

Address: ____

Phone: ____ **Fax:** ____

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.

Please note if you request a copy of your medical records for your own personal use there will be a $30 charge.

Signature of Patient: ____ Date: _______________________________

Signature of Legal Representative: ________________________ Relationship to Patient: __________________________

Patient Identifying Information:

Patient Name: ____ Date of Birth: ________________________________

Address: ____City______________ State___________ Zip Code_______

Phone Number: _______________________________ Date (s) of Service(s): **ALL MEDICAL RECORDS**

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 / 623 328-5979**

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

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Signature of Patient: ____ Date: ________________________________

Signature of Legal Representative: ________________________ Relationship to Patient: __________________________