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 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, LLc will not condition on my signing this authorization. Arizona State Urology, LLC 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, LLC Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to Arizona State Urology, LLC. 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 $50 charge.

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____

Arizona State Urology

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**

Disclosed from:

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)_____

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Signature of Patient: _____ Date:_____

Signature of Legal Representative: _____ Relationship to Patient: _____