ARIZONA ARTHRITIS & RHEUMATOLOGY ASSOCIATES, P.C.
Phone: (480) 443-8400 Fax: (480) 443-8697

Authorization for Disclosure of Protected Health Information

Patient Information: (please print)

Patient Full Name: _____ Other Names Used?_____
Patient Address: _____ Date of Birth:_____
City:_____State:_____Zip: _____ Phone: _____

Release Information From: (please print)

Name/Facility: _____ Attention: _____
Address: _____ Fax: _____
City:_____State:_____Zip: _____ Phone: _____

Release Information To: (please print)

Name/Facility: _____ Attention: _____
Address: _____ Fax: _____
City:_____State:_____Zip: _____ Phone: _____

Information to be Released: (please print)

☐ **Please provide a two year abstract of my records.**

☐ **Please provide my entire Medical Record for dates From:_____ to _____**

☐ **Other: Please be specific. Example*: X-rays of Spine done March 2008.* Use Comment Box.**

***Rates for patient requests: $15.00 clerical fee, plus $0.25 per page, plus postage & envelopes.**

Comment Box

Protected Information:

I, the undersigned, authorize the release of my health information as I have instructed. This includes the release of records relating to mental healthcare, treatment of alcohol or drug abuse and communicable disease testing and results, including HIV or AIDS.

Note: Many of our patients are tested for Hepatitis before starting on certain medications per safety protocol. The state of Arizona requires a Protected Information Release for communicable disease be signed before we can release this information. If you have requested no communicable disease information to be released, and you have been tested for Hepatitis, we may be unable to fulfill your request for records.

Initial either Box 1 or Box 2. If you choose Box 2, you must specify what NOT to release.

1. ☐ I authorize the release of my health record including the Protected Information noted above.
2. ☐ I DO NOT want the following information released: Initial appropriate box(es).

☐ **Mental Health** ☐ **Alcohol/Drug Abuse** ☐ **Communicable Disease (including HIV)**
☐ **Other Sensitive Information about: _____**

Patient Signature:_____ Date: _____
Signature of Parent or Legal Guardian: _____ Date:_____

This authorization expires 6 months from the date signed. I understand that I may revoke this authorization before the 6 month period of time by submitting a letter of revocation to AARA. I understand that under the applicable law the information described in this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. I understand that my treatment or continued treatment by AARA and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it. I understand that I may inspect or copy any information that is used or disclosed.

INTERNAL USE ONLY: EMR ONLY PAPER CHART (SCANNING COMPLETE)

LOCATION_____ EMPLOYEE_____DATE_____