



Arizona Institute
of Medicine & Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

DOB _____

Patient Name: _____

DOB _____

Patient Name: _____

DOB _____

Patient Name: _____

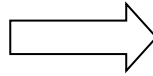
DOB _____

Authorization to release a copy, summary, or narrative of my medical records as indicated below:

- Complete Medical Records
 Labs / MRI / CT
 Progress Notes

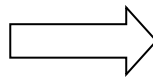
Specific Report: _____

Arizona Institute of Medicine & Pediatrics
 6828 E. Brown Road, Suite 102
 Mesa, Arizona 85207
 Office: (480) 981-8650
 Fax: (480) 981-1563



 Fax: _____

 Fax: _____



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 6828 E. Brown Road, Suite 102
 Mesa, Arizona 85207
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I understand:

- ✓ I may revoke this authorization except to the extent that is has already been acted upon.
- ✓ Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- ✓ Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.
- ✓ Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- ✓ I may have a signed copy of this authorization.

IN ORDER TO PROCESS YOUR REQUEST EFFICIENTLY AND IN A TIMELY MANNER, MEDICAL RECORDS FORWARDED ARE THOSE WHICH HAVE BEEN GENERATED BY THIS OFFICE. DOCUMENTS CONTAINED IN THE MEDICAL CHART GENERATED BY OTHER PHYSICIANS AND FACILITIES (E.G. OLD MEDICAL RECORDS AND CONSULTANTS' REPORTS) MAY BE FORWARDED UPON SPECIAL REQUEST.

Patient/Guardian Signature

Relationship to Patient

Date

This authorization will expire on: