AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Use this form only when East Valley Diabetes and Endocrinology (EVDE) needs to request a patient's records FROM another provider (for example, new patient intake or continuity of care). If a patient is asking to have their EVDE records sent elsewhere, do not use this form -- direct them to HealthMark Group at https://healthmark-group.com/.

Patient Name: *First / Middle / Last*	**Date of Birth: ____ / ____ / _____** *Month / Day / Year*
Other Names Used (if applicable):	**Medical Record Number (if known):**

I authorize the following provider/organization to release my medical records to East Valley Diabetes & Endocrinology (EVDE):

Provider/Organization: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: (____)_____ Fax #: (____)_____

Purpose of this request: ☐ New Patient Intake ☐ Continued/Coordinated Medical Care ☐ Other (specify): _____

Type of Records:

☐ Hospital/Inpatient ☐ Outpatient/Specialty Clinic (specify): _____

☐ Emergency Department/Urgent Care ☐ Radiology/Lab (specify location): _____

Records for Dates: From (Month/Year) _____ To (Month/Year) _____. If no date is specified, we request the most recent record.

☐ Discharge Summary	☐ Outpatient Clinic Progress Notes
☐ History & Physical	☐ Radiology & Other Diagnostic Reports
☐ Operative Report/Procedure Note	☐ Radiology & Other Diagnostic Images
☐ Lab Results/Pathology Report	☐ Medication List
☐ Immunizations	☐ Other: _____

Special Authorization for Sensitive Information Categories:

Federal and Arizona law give certain categories of health information heightened confidentiality protection. A general authorization above does NOT by itself authorize the release of these categories by the provider named above. If you want any of the following included, you must separately initial each applicable box:

☐ Substance use disorder diagnosis, treatment, or referral records protected under 42 C.F.R. Part 2 Initials: _____

☐ Mental health or behavioral health treatment records (not including psychotherapy notes, which require a separate authorization) Initials: _____

☐ HIV/AIDS testing or treatment information Initials: _____

☐ Genetic testing information Initials: _____

If a category above is not initialed, the named provider may exclude that information even if the record otherwise falls within the Type of Records selected above.

Notice: Once your health information is disclosed under this authorization, it may be redisclosed by the recipient and may no longer be protected by federal or state privacy law.

My Rights – I understand that:

• I may refuse to sign this authorization. This authorization is voluntary, and treatment, payment, enrollment, or eligibility for benefits from EVDE will not be conditioned on my signing it.

• I may revoke this authorization at any time by notifying EVDE's Privacy Officer in writing, except to the extent EVDE or the named provider has already taken action in reliance on it.

Expiration of Authorization: This authorization expires six (6) months from the date signed below unless another date or event is indicated here: _____

_____ _____

Signature of Patient/Legally Authorized Representative Date

_____ _____

Printed Name of Patient/Legally Authorized Representative Relationship to Patient

Please return this completed and signed form to EVDE at:

4100 S Lindsay Rd, Ste 130, Gilbert, AZ 85297 — Fax: 480-782-9530 — Email: manager@myazdr.com

For Internal Use Only:

Date Received: _____ Date Sent to Provider: _____ Date Records Received: _____

Staff Name: _____