



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

I authorize East Valley Diabetes & Endocrinology (EVDE) to: ☐ Release Records To ☐ Obtain Records From	
Recipient/Organization: _____ Attention: _____	
Address: _____ City: _____ State: _____	
Zip: _____	
Phone #: (____) _____ Fax #: (____) _____	
Information to be released by: ☐ Paper ☐ Encrypted USB Drive ☐ Fax ☐ Secure E-mail / Patient Portal	

Purpose of the release is: ☐ Continued Medical Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Disability ☐ School ☐ 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 release the most recent record.	
☐ Discharge Summary ☐ History & Physical ☐ Operative Report/Procedure Note ☐ Lab Results/Pathology Report ☐ Immunizations	☐ Outpatient Clinic Progress Notes ☐ Radiology & Other Diagnostic Reports ☐ Radiology & Other Diagnostic Images ☐ Billing Statements ☐ 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 release of these categories. 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: _____	
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If a category above is not initialed, EVDE will exclude that information from the release even if the record otherwise falls within the Type of Records selected above.

I authorize the following person to pick up the records on my behalf (photo ID will be required at pickup):

Name: _____ Date of Birth: _____

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 has already taken action in reliance on it, or where this authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer a right to contest a claim. The revocation takes effect once EVDE receives it.
- I understand the fee, if any, associated with this request, as described below.

Fee for Copies:

Consistent with A.R.S. § 12-2295, there is no charge when records are released: (a) to another health care provider for the purpose of your continuing care; (b) to you or your health care decision maker for the demonstrated purpose of obtaining health care; or (c) in other circumstances where a fee is prohibited by law. For releases not described above (for example, to an attorney, insurer, or other third party, or for personal use not related to obtaining health care), EVDE charges a reasonable, cost-based fee of \$25.00 per request, payable in advance except where continuity of care requires otherwise. This fee will be waived or reduced where required by law.

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

After completing the above information, please fax, e-mail, or mail this form (with payment, if applicable, made out to East Valley Diabetes & Endocrinology) to:

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

For Internal Use Only:

Date Received: _____ Fee collected (if applicable): \$ _____

Have the records been released to the requestor? ☐ Yes ☐ No Staff Name: _____

Date: _____