

1. PATIENT IDENTIFYING INFORMATION:

Patient Name (Please Print): _____

Patient DOB (MM/DD/YYYY): _____ Phone Number: _____

Address: _____

2. RELEASE OF MEDICAL RECORDS: I authorize Arizona Oncology Associates to release my medical records as indicated in **Section 3** below to:

Company/Individual Name: _____

Address: _____

Phone Number : _____ Fax Number: _____

Email: _____

3. INFORMATION TO BE RELEASED (check applicable boxes): I attest that the use or disclosure of protected health information (PHI) in this specific case is not otherwise prohibited by 45 C.F.R. 164.502(a)(5)

Date Range (MM/DD/YYYY): from _____ to _____

_____ Entire Record (Please specify exclusions in box below)

<input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other Communicable Diseases <input type="checkbox"/> Genetic Testing
<input type="checkbox"/> Developmental/Behavioral/Psychiatric Care <input type="checkbox"/> Treatment of Alcohol and/or Drug Abuse

Check Below if only requesting specific items and not entire record:

Lab Results
 Radiology Reports
 Operative Reports
 Pathology Reports
 Consult Reports

Other: Please Specify _____

I understand that Arizona Oncology, PC will not condition treatment on my signing this authorization. Arizona Oncology, PC 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 and cannot revoke this authorization, I can read Arizona Oncology, PC Notice of Privacy Practices. I attest that the use or disclosure of protected health information (PHI) in this specific case is not otherwise prohibited by 45 C.F.R. 164.502(a)(5).

To revoke my authorization, I must submit a written request to Arizona Oncology, PC. 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 regulations 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 associate's information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient or Description OR Authority to Act for Patient