ARIZONA PULMONARY & MEDICAL SPECIALISTS
3330 N 2nd Street, Suite 300
Phoenix, Arizona 85012
Tel: (602) 274-7195 Fax: (602) 274-7097

RECORDS RELEASE

Patient name: _____ Date of Birth: _____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Please disclose the following information (check all that apply):

- o All of my health information including, not limited to, AIDS/HIV and other communicable disease information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, unless specifically expressed: _____
- o My Health information relating only to the following treatment or condition: _____
- o My health information for the following date(s) of service: _____
- o Other (specify): _____

You may disclose this health information to:

Dr. _____ Arizona Pulmonary Specialists, Ltd.

Reason for this request:

- o Medical care
- o Other: _____

This authorization ends _____

I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment or enrollment) unless the purpose of this disclosure is either to participate in a research study or to create health information for a third party. I understand that I may revoke this authorization in writing at any time. However, I understand a revocation is not effective to the extent that my physician has relied on the use or disclosure of information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Once the information is disclosed, I understand this office may no longer be able to protect it. I understand I have a right to request a copy of this authorization.

_____ _____
Patient or legally authorized individual Date

_____ _____
Printed name Relationship

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