Arizona Center for Digestive Health
www.azcdh.com

MEDICAL RECORDS RELEASE
From Another Provider

Name: _____ DOB: _____ Phone _____

PLEASE OBTAIN INFORMATION FROM: _____ __

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

I AUTHORIZE the following information to be disclosed: (Please check mark all that apply)

_____ Entire GASTROENTEROLOGY Record
_____ Immunization Record
_____ Lab Tests
_____ TB Test
_____ Billing Records
_____ HIV Record
_____ STD Record
_____ Psychiatric/Mental Health
_____ Alcohol/Substance Abuse
_____ Other:_____

REASON for disclosure of health information: (Please initial only ONE option)

_____ At my request
_____ Continuing Care
_____ Insurance
_____ Other (please specify) _____

EXPIRATION of this Authorization (Please initial only ONE option)

_____ 90 days after signature date **OR** _____ On this date: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is not longer protected by Arizona Centers for Digestive Health, PLLC.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws

_____ _____
Patient Signature Date

☐ Pick-Up Records ☐ Mail Records ☐ Fax Records