# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **Arizona OBGYN Affiliates** (Maricopa OB/GYN Division) to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand copies of records received from other health care providers may not be released.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g., insurance company or health care provider; the released information may no longer be protected by Federal and State privacy regulations. I also authorize the release o f records by fax transmission and agree to hold **Arizona OBGYN Affiliates** (Maricopa OB/GYN Associates) harmless for errors in receipt of transmission.

I hereby request the release of the following medical information:

_____All Medical Records _____Obstetrical Records Only _____Past 2 Years

_____Laboratory Reports _____Operative Reports _____ Past 5 Years

_____Radiology Reports _____Pathology Reports _____ Billing

Other:_____

Records to be released to:

- o Hospital
- o Physician
- o Insurance Company
- o Attorney
- o Patient
- o Other _____

Name:_____

Address:_____

City, State, Zip:_____

Fax #: _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____.

I further understand that I may revoke this authorization at any time by notifying Arizona OBGYN Affiliates in writing. I understand the written revocation must be signed and dated with a date that is later than the date of this authorization

**It is further understood that there may be a fee, payable by the patient, for releasing these records.**

PRINT PATIENT NAME:_____

DATE OF BIRTH:_____

TELEPHONE NUMBER_____

Signature of Patient or Legal Guardian_____

Date_____

If other than patient, print name here_____

Relationship to Patient_____

Legal Authority (attach supporting documentation)_____

Witness Signature_____