ARIZONA COMMUNITY SURGEONS, PC

Authorization for Release of Confidential Medical Records

Patient's Name: _____ Date of Birth: _____

I hereby authorize Arizona Community Surgeons, P.C. ("ACS") to provide the following persons or entities with a copy of my confidential medical records (print name and address of person/entity):

_____

_____

For care provided to me by the following provider(s): _____

_____

For the following date(s) of service: _____

Disclosure of the information is requested for the following purpose(s): _____

_____

I authorize the disclosure of the following information:

- ☐ Treatment records including progress notes, history and physical reports, procedure and operative reports and consult reports
- ☐ Include lab results and pathology reports
- ☐ Include diagnostic imaging (e.g. x-ray) reports and/or EKG/Cardiac or other diagnostic testing reports
- ☐ Include photographs and videos
- ☐ Include outside records from other providers
- Yes ☐ No ☐ Include information related to communicable diseases such as Hepatitis C, Tuberculosis, etc., and including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases
- Yes ☐ No ☐ Include information related to genetic screening
- ☐ Include billing records
- ☐ Other information not specified: _____

*** Please check all appropriate boxes or we will be unable to process your request. ***

This authorization is valid for six (6) months from the date signed below and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ _____ _____

Patient or Representative's Signature | Date | Relationship (if not self)

_____ _____

Witness | Date