ARIZONA DIGESTIVE HEALTH

Authorization to Release/Obtain Medical Records

Today's Date: _____/_____/_____

Patient Name: _____
(First) (MI) (Last)

Date of Birth: _____/_____/_____ ADH Physician: _____

Phone: _____ Email: _____

Records Released From:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Records Released To:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Information to be Release/Obtained:

☐ Complete Medical Record ☐ Lab Reports ☐ Billing Records ☐ Clinical Records Related To:

_____

_____

☐ I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

☐ I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization. Unless otherwise revoked, this authorization will expire one (1) year from the signing date.

☐ I authorize Arizona Digestive Health, P.C. to release or obtain medical records as specified above.

_____ _____/_____/_____
Signature Date

_____
Printed Name