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2775 S. 8th Ave
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Phone #: (928) 341-0700
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's full name _____ Chart # _____

Address _____ Date of Birth _____

City_____ State _____ Zip _____ Social Security # _____

THIS AUTHORIZES: Physician/Provider/Company/Person/Facility:

Name _____

Address_____

City _____ State _____ Zip _____ Phone #: _____

Fax #: _____

TO PROVIDE INFORMATION: Physician/Provider/Company/Person/Facility:

Name **Up 2 Par**

Address **2775 S. 8th Ave**

City **Yuma** State **AZ** Zip **85364** Phone #: **(928)341-0700**

Fax #: **(928)341-0900**

INFORMATION TO BE RELEASED: Specify dates of treatment):

_____ Entire Records (Unless Specified, 1 yr only)

_____ Other _____

In Accordance with Federal Regulations 42 CFR Part 2, I hereby consent to the release of records pertaining to:

_____ CONDITIONS RELATED TO DRUG AND/ OR ALCOHOL ABUSE

_____ CONDITIONS RELATED TO PHYCHIATRIC/PSYCHOLOGICAL TREATMENT

_____ACQUIRED IMMUNE DEFICIENCY SYNDROME (aids) (as defined in A.R.S., Section 36-661)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing a present my written revocation in the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocations will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless other wise revoked, this authorization will expire in 12 months.

I understand that authorizing the discloser of this health information is voluntary. I can refuse to sign this authorization; I need not to sign this form in order to assure this treatment. I understand that I may request copies of information to be used or disclosed, as provided in CPR 164, 574. If I have any questions about disclosure of my health information I can contact the DEPARTMENT OF MEDICAL RECORDS.

***Signature of Patient_____ Date _____

If a patient is minor and information to be released is regarding treatment for psychiatric, alcohol/or drug abuse, both patient and the parent or legal guardian must sign

IF THE PATIENT IS DECEASED: I affirm that the patient is deceased, that no personal representative of his estate has been appointed and that I am the patient's _____ _____ _____

Relationship Signature Date