ARIZONA FOCAL PROSTATE CENTER

Authorization to Release Health Information

I hereby authorize Arizona Focal Prostate Center, or any of its employees, staff, or agents to use and disclose health information from the medical records of:

_____

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____Phone (_____)_____

Date(s) of treatment/records requested from:_____ to: _____

_____

At my request, Arizona Focal Prostate Center may release the following information:

□ Entire record □ Financial records □ Operative Reports □ Office visit notes

****Financial Compensation may be required for this request****

Person who will receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____ Fax _____

☐ **Send the information electronically. Email address: _____**

☐ For **email/fax communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward with email/fax communications.

☐ Medical records are to be **picked up by patient**

☐ Medical records to be mailed to the patient at the following **Address: _____**

☐ Medical records to be faxed at the following **Fax number**: (_____) _____

For the release of records to another entity:
Initial: _____ I permit the confidential information to be released for the following purpose:

☐ Continuing Medical Treatment

☐ Litigation

☐ Insurance Company

☐ Other (Specify) _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing
- I understand released information may include a communicable disease diagnosis such as HIV.

This consent permits Arizona Focal Prostate Center to use and disclose my health information to carry out treatment, payments, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in Arizona Focal Prostate Center's notice of privacy practices, A patient has the right to review the "notes" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operation purposes. However, Arizona Focal Prostate Center is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing at any time, except to the extent that action has already been taken. No further confidential information is released without execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the practice, its employees, staff, and agents in connection with the disclosure of information ser forth relating to these medical records.

Patient Name: _____ Signature: _____ Date: _____
Print Name

Authorized Representative Name: _____ Relationship: _____
Print Name

Signature of Representative: _____ Date: _____

*****This request may take 10 business days to process. If there are questions, please contact our office at (520) 838-9005.**