1. PATIENT IDENTIFYING INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code: _____

Phone Number: _____ Date(s) of Service(s): _____

A. Release of medical records:

I authorize _____ to release my medical records as I have indicated in ***Section 2*** below:

Disclose to: _____

Address: _____

Phone Number: _____ Fax Number: _____

2. **SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED** (check all that apply): _____ Entire Record

_____ Discharge Summary _____ History and Physical Exam _____ Operative Reports _____ Pathology
_____ X-Ray Reports _____ Lab Tests _____ Consultations _____ Pertinent Records Only

Other (Specify) _____

Specific description of the purpose of the disclosure:
_____ Continued Patient Care _____ Worker's Comp _____ Insurance/Payment of Care
_____ The disclosure is at the patient's request Other (Specify) _____

I authorize the provider to use or disclose information related to:
_____ AIDS/HIV _____ Genetic Testing Information
_____ Psychiatric Care Reports _____ Alcohol and/or Drug Abuse Treatment

I understand that Arizona Oncology, PC will not condition treatment on my signing this authorization. Arizona Oncology, PC will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read Arizona Oncology, PC Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to Arizona Oncology, PC. Unless I revoke the authorization earlier, it will expire upon its completion or 180 days from the date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description OR Authority to Act for Patient