Arizona Centers for Digestive Health
A Covenant Physician Partner

# MEDICAL RECORDS RELEASE

Sent to Patient Only

Name _____ DOB _____ Phone _____

**I AUTHORIZE** the following information to be disclosed: (Please **check mark** all that apply)

_____ Entire Gastroenterology Record
_____ Immunization Record
_____ Lab Tests
_____ TB Tests
_____ Billing Records
_____ HIV Record
_____ STD Record
_____ Psychiatric/Mental Health
_____ Alcohol/Substance Abuse
_____ Other: _____

**REASON** for disclosure of health information: (Please initial only **ONE** option)

_____ At my request
_____ Continuing care
_____ Insurance
_____ Other (please specify) _____

**EXPIRATION** of this Authorization: (Please initial only **ONE** option)

_____ 90 days after signature date **OR** _____ On this date: _____

ADDITIONAL PATIENT INFORMATION:

» I understand that I have the right to withdraw this authorization

» I understand that once my health care information is disclosed as I have authorized, it could be disclosed by the recipient and is no longer protected by Arizona Centers for Digestive Health, PLLC.

» I understand that signing this authorization does not cancel any rights I have under other state or federal laws

_____ _____

Patient Signature Date

☐ Pick-Up Records ☐ Mail Records ☐ Fax Records

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# MEDICAL RECORDS RELEASE

From Another Provider

## AZCDH Location

☐ East Avondale ☐ West Avondale ☐ Gilbert ☐ Glendale ☐ Maricopa ☐ Mesa

☐ South Phoenix ☐ West Phoenix ☐ Queen Creek ☐ North Scottsdale ☐ Arizona West Endoscopy