Arizona Centers for
Digestive Health
A Covenant Physician Partner

MEDICAL RECORDS RELEASE

Send to Another Provider

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

Please list only ONE physician per form

PLEASE SEND INFORMATION TO:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

______________________ ______________________
Phone Fax

☐ MAIL RECORDS ☐ FAX RECORDS

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AZCDH Location

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

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