VALLEY ARTHRITIS CARE

Peoria Office
13943 N. 91st Ave. Bldg. I, Peoria, AZ 85381

Sun City West Office
13613 W Camino Del Sol #4, Sun City West, AZ 85375

AUTHORIZATION TO RELEASE MEDICAL RECORDS & DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name: _____ Date of Birth:_____

Patient's Address:_____Telephone Number:_____

I AUTHORIZE THE RELEASE OF INFORMATION IN MY HEALTH CARE RECORD:

FROM:

Facility Name_____Address: _____

Facility Phone Number: _____Facility Fax Number: _____

TO:

Facility Name_____Address: _____

Facility Phone Number: _____Facility Fax Number: _____

INFORMATION TO RELEASE

- **Patient records of the past three years of treatment.**
- **All medical records** (I understand this requires approval from the privacy officer and may take up to 30days)
- **Medical Records from:_____ TO_____**
- **Specific records: (from the past year) □Billing □Office Notes □Labs □X-Ray □Bone Density**
- **Other: (please explain and provide dates: _____**

Purpose: □Patient Request □Continue Medical Care □Attorney Request □Other

I understand that my health records may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency; (AIDS), Human Immunodeficiency Virus (HIV), Hepatitis C, and other communicable disease, Behavioral Health Care, Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes the release of such information. I may refuse to sign this authorization and understand that Valley Arthritis Care will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time in writing except to the extent that actions has taken based on this authorization, unless otherwise revoked this authorization is calid for one year.

I understand that once my information is released, Valley Arthritis Care will no longer be able to protect that information. I release Valley Arthritis Care and its employees from any legal liability that may arise from the disclosure of the above information.

I understand there is an administrative fee associated with to duplication of my records. Please allow 7-10 days for any duplication of records. For the release of all medical records please allow 30days.

Patient/Legally Authorized Representative Signature: _____ Date: _____