CONSULTANTS IN INTERNAL MEDICINE, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name:_____ Phone: _____
Address:_____
Date of Birth: _____
This authorizes (Physician Name):_____
(Address):_____
To release information specified to (Name):
(Address): _____

This authorization releases CONSULTANTS IN INTERNAL MEDICINE, P.C. and any of its staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from my person, or distress of any type caused to me or others. CONSULTANTS IN INTERNAL MEDICINE, P.C. will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

Please check the following:
Photocopies of information to be released:

- Medical Records of the past two (2) years of treatment
- All records in Consultants In Internal Medicine
- Other (Specify):

I authorize release of records pertaining to:

- All HIV-related information and communicable disease-related information (ARS 36-661)
- Conditions related to psychiatric/psychological treatment

IN ACCORDANCE WITH FEDERAL REGULATIONS 42 CFR PART 2, I HEREBY CONSENT TO THE RELEASE OF RECORDS PERTAINING TO TREATMENT/DIAGNOSIS OF THE FOLLOWING:

- Conditions related to drug and/or alcohol abuse

This information is needed for the following purpose(s):

_____

By marking this box you are notifying us of a permanent transfer OUT of this office

I understand I may revoke this consent at any time and that upon fulfillment of the above-stated purpose(s), this consent will automatically expire one (1) year following date of signature without my express revocation. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____ _____ _____ _____
Signature of Patient or Representative Date Signature of Witness Date

Relationship to patient: _____ Reason patient was unable to sign:

Note: There is important information on the back of this form for recipient of records.

IMPORTANT INFORMATION / NOTICES FOR THE RECIPIENT OF MEDICAL RECORDS

The attached photocopies of medical records are sent to you pursuant to the authorization and request the patient specified on the front of this consent submitted to Consultants In Internal Medicine. P.C..

It is the practice of Consultants In lnternal Medicine, P.C. to release (upon authorization) photocopies of medical records as requested by a patient. There may be additional records/ medical information available. The patient may be required to sign a specific authorization for the release of additional information.

If you received any medical records which included confidential HIV-related information or confidential communicable disease-related information as defined in A.R.S. Section 36-2661, the following notice of redisclosure applies under Arizona law:

THE INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RE-CORDS WHICH ARE PROTECTED BY STATE LAW THAT PROHIBITS FURTHER REDISCLOSURE OF THE INFORMATION WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMTTTED BY LAW. (A.R.S. SECTION 36-664 G)

If you received any medical records which included confidential alcohol or drug abuse related information as defined in 42 CFR Section 2.1 et seq., the following notice on redisclo-sure applies under the federal law.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PRO-TECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART II). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THE INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART II. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.