EAST FLAGSTAFF FAMILY MEDICINE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please fax all requested records with this form to fax listed below

Phone: 928-774-2788
Fax: 928-774-0123

**** RECORDS NEEDED STAT ****
(please circle if needed)

I authorize _____ to disclose the following information from my health record:

Phone number for facility: _____ Fax number for facility: _____

Patient Information	_____ Patient Name _____ Date of Birth _____ Address (_____) _____ Phone Number _____ City _____ State _____ Zip Code
Information Requested (most recent unless otherwise specified)	Service Dates From: _____ To: _____ All records (please circle) ☐ All pertinent records ☐ History & Physical ☐ Mammogram ☐ Colonoscopy with recall date ☐ Imaging (last year) ☐ Mammogram (all) ☐ Consultations ☐ Imaging (all records) ☐ Medication List ☐ Discharge Summaries ☐ Immunizations ☐ Operative reports ☐ Echocardiogram ☐ Labs (last year) ☐ Pathology reports ☐ ER Reports ☐ Labs (all labs) ☐ Pap with HPV ☐ Other: _____
Other HPI	I authorize disclosure of information related to (check all that apply) : ☐ AIDS/HIV and related illnesses ☐ Drug & alcohol treatment ☐ Psychological/psychiatric information including diagnosis & treatment ☐ Pathology slides, x-rays, videotapes, photographs
Purpose	☐ Self ☐ Insurance ☐ Continuing medical care ☐ Other (please specify): _____
Information to be released to	_____ Practice/Facility/Company Name (_____) _____ Fax Number _____ Address (_____) _____ Phone Number _____ City _____ State _____ Zip Code

This authorization is valid for one year from the date of signing and may be revoked at any time with a written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ Patient Signature Date

_____ Patient Representative Signature/Relationship

_____ Printed Name

_____ Printed Name

Revised May 2022