ARIZONA INTERNISTS

Authorization to Release Records

6565 E Greenway Pkwy Ste 102, Scottsdale, Arizona 85254 Phone (480) 900-7595 Fax (480) 739-0262
Michael Germain, M.D. & Danielle Wicklow, M.D.

PATIENT INFORMATION

I authorize Arizona Internists PLLC to disclose health information of:

Legal Name | DOB (MM/DD/YYYY) | Phone Number | Email Address

Address | City | State | ZIP Code

RECORDS FROM

I authorize health information from:

Provider / Practice | Specialty | Phone | Fax

Address

INFORMATION TO BE DISCLOSED

To be disclosed to: Arizona Internists, 6565 E Greenway Pkwy Ste 102, Scottsdale, AZ 85254 · Fax (480) 739-0262

MEDICAL RECORDS including: visit notes, lab results, diagnostic reports, imaging reports, consult notes

- ☐ All records
- ☐ Clinical notes
- ☐ Immunizations
- ☐ Medications
- ☐ Laboratory results
- ☐ Consult notes
- ☐ Imaging/procedure results

Records From (date) | Records Through (date)

Purpose: ◯ At patient's request ◯ Other (specify)

TERMS

I understand that the information released may contain other sensitive information about the patient, such as information regarding communicable diseases (including sexually transmitted diseases and HIV/AIDS), genetic testing/genetic history, mental/behavioral health, substance use disorders and developmental disabilities. I consent to the disclosure of this other sensitive health information in connection with the release of the patient's health information.

I understand that the provider will not condition treatment, payment for treatment, enrollment or eligibility for benefits on my signing this authorization form. I understand that I may refuse to sign this authorization form. I also understand that I may revoke this authorization. To revoke my authorization, I must submit a written request to Arizona Internists PLLC. Unless I revoke this authorization earlier, it will expire on the following date, event, or condition:

Expiration date, event, or condition

I understand that, if this information is disclosed to a third party, the information may no longer be protected by applicable privacy laws and may be redisclosed by the person or organization that receives the information. I have been given a copy of this form.

Signature of Patient or Patient's Authorized Representative | Date | Printed Name

Relationship to Patient or Description of Authority to Act for Patient (if applicable)