Gila Valley Clinic, P.C
1680 S. 20th Avenue
Safford, AZ 85546

Phone – (928) 428-1377
Fax – (928) 428-6903

Authorization to Release Medical Records

If release is not fully completed it will NOT be processed.

<u>ATTENTION</u>: **PLEASE MAIL RECORDS IF MORE THAN 15 PAGES**

<u>Patient Information:</u>
Name:______________________________Other Name Used:_______________________ Birthdate:________
Address:____Phone: (   )________________

<u>Copies Released From:</u>
Name:___________________________________Phone: (   )_____________ Fax: (   )_________________
Address:____

<u>Copies Released To:</u>
Name:___________________________________Phone: (   )______________ Fax: (   )_________________
Address:____

<u>Please mark items to be released:</u>
______ Progress Notes
______ Laboratory
______ X-Ray
______ Other (specify)
______ All records and progress notes of past two (2) years.
______ Selected Dates_______________

<u>Purpose for requesting these records:</u>
_____ Further Treatment
_____ Changing Primary Care Physician
_____ Other (Specify) _________________
_____ Personal Use - **($20.00-$45.00 fee assessed plus $0.10 per page)**

In signing this release, I authorize the release of data and information relating to substance abuse (alcohol, legal drugs, etc) mental health (psychological evaluation and treatment), and HIV related information (AIDS related testing). With respect to any substance abuse treatment information, mental health records, and/or communicable disease related information protected by State and Federal Law and released pursuant to this authorization, the recipient understands that it is prohibited from making any further disclosure of this information without specific written consent of the patient, or as otherwise permitted by law/regulations.

I may revoke this authorization at any time by providing written notice of revocation. However, I may not revoke the authorization retroactively for information already released. This authorization is considered invalid after 6 months or 60 days with respect to State or Federally protected records from the date of the signature.

Signature of patient or Authorized Adult:___________________________________ Date:__________________

If patient is unable to consent for reasons of age or other factors, please state reasons: ______________________
____ Relationship to patient: ___________________

<u>NOTICE</u>: Please allow up to **ONE WEEK** for release and records to be processed and completed.