El Dorado Urology & Prostate Center

Phone (520) 202-3606 ▪ Fax (520) 202-3608
1100 N. El Dorado Pl. ▪ Tucson, AZ 85715
Toll Free (855) 292-9849

Authorization for Release of Medical Information

_____
Medical Record #

Please complete all pates of this form, sign, and return to:

El Dorado Urology & Prostate Center
1100 North El Dorado Place
Tucson, AZ 85715

PATIENT IDENTIFICATION

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Previous Name: _____ SSN: _____

Patient Phone #: _____

I request and authorize El Dorado Urology & Prostate Center to release medical information of the patient named above.

RELEASE RECORDS TO: (Where records should be sent)

☐ ***Same as above***

Name/Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

For Doctors or other HealthCare Providers Only

E-mail Address: _____

☐ Mail
☐ Pick up in Person
☐ Fax
☐ Electronic

INFORMATION REQUESTED

Dates from: _____ to _____ Or specific date: _____

☐ History and Physical ☐ Radiology Reports ☐ Office/Clinic Notes

☐ Discharge Summaries ☐ Cardiac Reports ☐ FMLA

☐ Operative/Procedure Notes ☐ Pathology Reports ☐ Power of Attorney

☐ Consultations ☐ Lab Results

☐ Other (specify): _____

PURPOSE OF RELEASE

☐ Patient Care ☐ Appointment/Sharing with other HealthCare Provider as needed

☐ Personal Use ☐ Disability/Insurance Application/Claim

☐ Administrative (i.e. FMLA) ☐ Attorney/Legal Case

☐ Other (specify): _____

Authorization for Release of Medical Information

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.

I also understand that if I do not ask for my legal medical record or specify the records I want, the Medical Information Services department will send an abstract of my legal medical record.

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES

(You must check one): I do _____ do not _____ authorize this information to be released.

I would like to limit the information to: _____

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- I understand that this authorization will expire when the records are released for the request dated below. Any requests after this date will need a separate authorization.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.
- I get a copy of this form after I sign it.

Printed Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____

Date: _____ **Time:** _____

Relationship to Patient: _____