



Agave Family Physicians, PLLC

Maricopa Professional Village
21300 North John Wayne Parkway, Suite 123
Maricopa, AZ 85239
Office: (520) 494-7778

Authorization For Release Of Information

I, _____, do hereby request disclosure of information from my record.

II. The information is to be released from:

Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Please mail to the above address Please fax to the following number : _____

III. The information shall include:

- | | | |
|---|--|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Reproductive Records |
| <input type="checkbox"/> Inpatient Progress Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Alcohol/Drug Treatment |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Outpatient / Clinic Notes | <input type="checkbox"/> HIV Results |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Immunization Records | |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Billing Records | |

IV. The information shall be from the time period between _____ and _____.

V. The purpose of this release of information is to:

- maintain continuity of care.
- _____.

VI. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature below.

Patient Signature: _____ Date: ____ / ____ / ____

Printed Name: _____ DOB: ____ / ____ / ____

Signature Of Parent, Guardian or Authorized Representative: _____ Date: ____ / ____ / ____

Name of Parent, Guardian or Authorized Representative: _____ Relationship: _____