



Agave Family Physicians, PLLC

Maricopa Professional Village
21300 North John Wayne Parkway, Suite 123
Maricopa, AZ 85139
Office: (520) 494-7778

Authorization For Release Of Information

I. 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 records to the above address OR fax to 520-494-7779 ***
PLEASE DO NOT SEND RECORDS ON DISC

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"/> _____ | |

IV. The information shall be from the time period between January 1, 2014 and the date noted below.

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 If this authorization has not been revoked, it will terminate one year from the date of my signature below.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: _____