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:**

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Inpatient Progress Notes
- ☐ Consultation Report
- ☐ Emergency Room Record
- ☐ Operative Report
- ☐ Laboratory Results
- ☐ X-Ray Reports
- ☐ Pathology Reports
- ☐ Outpatient / Clinic Notes
- ☐ Immunization Records
- ☐ _____
- ☐ Mental Health Records
- ☐ Reproductive Records
- ☐ Alcohol/Drug Treatment
- ☐ HIV Results

IV. **The information shall be from the time period between 1/2012 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 If this authorization has not been revoked, it will terminate one year from the date of my signature below.**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:** _____

(v1.14)