# Arizona State Urological Institute

*The Center for Comprehensive Urological Care*

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

*Patient Name:* _____ *Date of Birth:* _____ *Contact Number* _____

*Patient Mailing Address:* _____ *City* _____ *State* _____ *Zip code* _____

Release Information **to**:

Arizona State Urological Institute, LLC
2730 S Val Vista Dr. Bldg. 13, Suite 177
Gilbert, AZ 85295
Phone**:** 480-394-0200 **| Fax: 480-394-0202**
**Email:** www.medicalrecords@asui.org

Release Information From:

_____

_____

**Phone: _____| Fax: _____**

☐ *For the purpose: Upcoming appointment*

*Please forward the following records to ASUI:*

☐ All Records
☐ Other: _____

**I DO** authorize the release of this type of information.
**I DO NOT** authorize the release of this type of information.

***Patients:*** This form allows our office to request medical records on your behalf from other physicians, hospitals, and care providers to better coordinate your care. Please fill out the form to the best of your ability. Please make sure to sign and date form.

**Medical Records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.**

Release Information **from ASUI**:

**I hereby authorize,** Arizona State Urological Institute, LLC to release my confidential health records to:

Provider Name: _____

Address: _____

City: _____State: _____

Phone: _____

Email: _____

**Fax:** _____

*For the purpose: upcoming appointment*

☐ Upcoming appointment
☐ Transfer of care
☐ Personal Request
☐ Other: _____

Please forward the following records:

☐ All Records
☐ Other: _____

**Medical Records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.**

**I understand that:**

- I may revoke this authorization, except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

_____ _____

Patient Signature or Personal Representative of Patient Signature Date: