DMG
DISTRICT MEDICAL GROUP

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information: (Please Print)

Patient's Name: _____MRN:_____ DOB: _____

Phone Number: _____Address: _____
Street City State Zip Code

District Medical Group (DMG) Clinic: (please select all that apply)

- ☐ DMG Anthem Family Practice, 3624 W. Anthem Way, Ste. C-122 Anthem, AZ 85086, PH: 623-434-5748, FX: 623-551-8822
- ☐ DMG Arrowhead Family Practice, 15182 N. 75th Ave., Ste. 180 Peoria, AZ 85381, PH: 623-487-3334, FX: 623-487-3656
- ☐ DMG East Mesa Internal Medicine, 6315 E. Main St., Ste. 4 Mesa, AZ 85205, PH: 480-830-4164, FX: 480-830-5009
- ☐ DMG Lake Pleasant Family Practice, 10144 W. Lake Pleasant Pkwy., Ste. 1110 Peoria, AZ 85382, PH: 623-434-5748, FX: 623-566-9665
- ☐ DMG Papago Family Practice, 1805 N. Scottsdale Rd., Ste. 109 Tempe, AZ 85281, PH: 602-470-5550, FX: 602-381-7500

I authorize the release of DMG Health Information: Select ☐ to ☐ from

Name of Designated Recipient or Facility: _____

Address: _____
Street Suite # City State Zip Code

Phone Number: _____ Fax Number: _____

Delivery Method:

- ☐ Mailed
- ☐ Pick Up
- ☐ Faxed

Specific Description of the Purpose/Reason of the Disclosure:

☐ Continued Patient Care ☐ Care Coordination ☐ Insurance Coverage or Payment for Care
☐ Legal ☐ Personal Use ☐ Workers Compensation
☐ Other (Specify)_____

I authorize the provider to use or disclose information related to Medical and/or Behavioral Health (check all that apply):

☐ Full Medical Records ☐ History & Physical ☐ Laboratory Reports
☐ Genetics ☐ Medication Records ☐ Radiology Reports
☐ Substance Abuse ☐ HIV/AIDS ☐ Behavioral Health
☐ Other (Specify) _____ ☐ Abstract of record (Provider Notes, Procedures, & Test Results Only)

☐ Progress Notes (specify) _____

Date(s) of Treatment: ❑ Specific Date(s): _____through_____ or ☐ All Date(s) of Treatment

Patient Rights:

- I understand that this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. The provider will not deny me treatment if I do not wish to sign this form. I understand that I may refuse to sign this authorization form.
- I understand that by choosing "Full Medical Record", records that are released or obtained may include up to, but not limited to, psychological, psychiatric, or other mental impairments or treatment, including therapy notes, drug abuse, alcoholism, or other substance abuse, records which may indicate the presence of communicable or no communicable diseases, and/or tests for, or record of, HIV/AIDS, and gene-related impairments, including genetic testing results.
- I may revoke this authorization at any time, with some exceptions, my revocation must be in writing and the request must be submitted to Medical Records. The revocation will take effect when DMG receives it, except to the extent that DMG or others have already relied on it.
- Unless otherwise specified or revoked in writing, this Authorization will expire 1 year from the date of signature.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
- I am entitled to receive a copy of this Authorization.
- I understand the matters discussed on this form. I release DMG, its employees, agents, officers, directors and medical staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____
Patient Signature Print Name Date

_____
Legal Representative Signature Print Name Relationship to Patient

TO AVOID DELAY IN PROCESSING: INCLUDE COPY OF PHOTO ID WITH SIGNED RELEASE FORM