MIGUEL A ARENAS, M.D., P.C.

Board Certified in Gastroenterology and Internal Medicine

7445 E Tanque Verde Road • Tucson, Arizona 85715 • (520) 722-0744 • Fax (520) 722-0745

CONSENT FOR OBTAINING OR RELEASING INFORMATION FROM MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

OBTAIN MEDICAL RECORDS:

FROM: _____ TO: __Miguel Arenas, M.D._____

Preferred Method of Contact: Phone: Home: _____ Cell _____ Work _____
Can we leave a message on an answering machine? Please circle one: Yes No
Can we leave a message with you medical information with another person at the above numbers? If so, please list names here: _____

The information to release is:

□ **Entire Chart** □ **Other _____**

Purpose of Disclosure:

□ **Continued Care** □ **Insurance** □ **Personal** □ **Legal**

There may be a fee to copy medical records for insurance, legal or personal purposes.

In addition to the general authorization to release medical records, I further authorize release of the following information if it is contained in my medical record. Please initial to release or not release the following records.

	May Be Released	**May Not Be Released**
Drug and alcohol abuse	_____	_____
Mental Health	_____	_____
Diagnosis/Treatment of HIV, HIV-related illness and communicable disease related information	_____	_____

This authorization shall be considered invalid after 6 months or 60 days with respect to drug, alcohol, psychiatric or HIV/AIDS records from date of signing. I may revoke this authorization at any time by providing written notice of revocation. However, I may not revoke the authorization retroactively for information already released. In furtherance of this authorization, I hereby waive all provisions of law and privilege relating to the disclosures hereby authorized.

With respect to drug and alcohol abuse treatment information, or records regarding communicable disease released information, the recipient of this information understand that it is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Patient's Signature: _____ Date: _____

Power of Attorney or Authorized Signature: _____ Date: _____