MESQUITE

Gastroenterology and Surgery Center

CONSENT FOR OBTAINING OR RELEASING INFORMATION FROM MEDICAL RECORDS

PATIENT NAME:_____
DOB:_____

OBTAIN MEDICAL RECORDS FROM:

_____

_____

_____

_____

RELEASE TO:

THE INFORMATION TO RELEASE IS:
ENTIRE CHART:_____ **OTHER:**_____

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 TO RELEASE THE FOLLOWING RECORDS.

	MAY RELEASE	MAY NOT RELEASE
DRUG AND ALCOHOL ABUSE	_____	_____
MENTAL HEALTH	_____	_____
DIAGNOSIS/TX OF HIV/ HIV RELATED ILLNESS AND COMMUNICABLE DISEASES	_____	_____

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. 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 understands 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 SIGNATURE:_____**DATE**_____
POWER OF ATTORNEY OR AUTHORIZED SIGNATURE:_____**DATE**_____

7445 E. Tanque Verde Road Tucson, Arizona 85715 520-722-0744 office 520-722-0745 fax