Release of Information

The Aleph Center, P.L.L.C.
6408 E. Tanque Verde Rd.
Tucson, Az. 85715
(520)885-5558 Fax (520)885-5559

Printed Name: ______________________ Date of Birth: ______________

Street Address: ____

City, State, Zip Code: ______________________ Telephone: ______________

1. **Information to be disclosed-Covering the Periods of Health Care**: (There may be a fee for copying these records).
   From (date) ______________ To (date) ______________
   - ❑ Complete Health Record(s)
   - ❑ Progress Notes
   - ❑ History and Physical Examination
   - ❑ Laboratory Tests
   - ❑ Consultation Reports
   - ❑ X- Ray Films
   - ❑ Reports only
   - ❑ Photographs, videotapes, digital/other images
   - ❑ Verbal Communication Only **(DO NOT SEND RECORDS)**
   - ❑ Other (Please specify) ______________

Please Mail If Over 20 Pages!!!

2. **Purpose of Request:**
   - ❑ Treatment/Consultation
   - ❑ Insurance Copy
   - ❑ Attorney
   - ❑ Personal Copy
   - ❑ Verbal Communication Only **(DO NOT SEND RECORDS)**
   - ❑ Other (Please specify) ______________

Person Authorized to Disclose Information:

____

____

Person Authorized to Receive Information

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4. **Drug and/or Alcohol Abuse, Communicable Disease, Psychiatric, and or HIV/AIDS/Genetic Testing Records Release:**

I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Diseases, Psychiatric, and/or Genetics Testing may be released. ______Yes (initials) ______No (initials)

I agree that any medical or billing record containing information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment may be released. _______Yes (initials) ______No (initials)

5. **Time Limit & Right to Revoke Authorization:**
   I understand that I can revoke this authorization at any time by submitting a written notice to the Custodian of Records at the location where records are located; however, I understand that if I do not act quickly to revoke this authorization, my records may have already been released.
   Unless revoked, this authorization will be valid until the information is released.

6. **Re-disclosure:**
   I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The Aleph Center, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information.

7. **Signature of Patient or Personal Representative Who May Request Disclosure:**

   Signature ______________________ Date: ______________

   Print ______________________ Authority to sign if not patient ______________

8. Witnessed by: ______________________