Arizona Living Well Institute
Advancing Evidence-Based Programs for Arizona

Health Records Release Form

Patient Name: _____ Date of Birth: _____

Patient/Guardian Authorization

You may use or disclose the following health care information:

☐ All my health information including, but not limited to, Chronic Condition Diagnoses and other Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted: _____

☐ Other _____

You may disclose this health information to:

Name: _____

Address: _____

Phone: _____ Fax: _____

Do you want us to ☐ fax or ☐ mail your health records?

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (legal guardian)