Medical Records Release- TO ALH

I **authorize** the provider listed below to provide medical records to Arizona LiverHealth, formerly *The Institute for Liver Health*.

Provider(s) Name: _____

_____

Address:_____City:_____State:_____Zip Code:_____

Phone: _____Fax: _____

Medical records may include confidential information related to HIV, communicable disease, alcohol, drug abuse and mental health diagnosis and treatment.

___Yes, I authorize ___I **do not** Authorize

Records Requested:

Complete Medical Records	Operative/ Discharge
Pathology and Procedures	Progress Notes
Hospital Reports	Radiology Reports
Labs and Reports	Other_____

I understand that:

- I may revoke this authorization at any time, except to the extent that it has already been acted upon
- Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of created protected health information for disclosure to a third party
- Once this information is released, it may be re-disclosed by the recipient and may nolonger be protected information

I authorize Arizona Liver Health to access the Health Information Exchange to retrieve records related to my the above listed history and records.

_____ _____

Signature of Patient or Legal Representative Date