Albert S. Callie, MD PC
6636 E. Carondelet Drive

Tucson, AZ 85710

AUTHORIZATION TO RELEASE /REQUEST PATIENT HEALTH INFORMATION

Patient Name _____ Date of Birth _____ /_____ / _____

Contact phone #'s _____ _____ email _____

- ❑ I hereby authorize **Albert S. Callie, MD, PC** to send the record of my care to:
- ❑ I hereby authorize **Albert S. Callie, MD, PC** to request the record of my care from:

_____
Organization / Person

_____
Street Address City, State, Zip

_____ _____ _____
Phone Fax# email (if HIPAA compliant)

PURPOSE OF RELEASE:
❑ Moving ❑ Personal use ❑ Specialist Appointment ❑ Transfer to another provider ❑ Daycare / School ❑ Dissatisfaction

❑ Other _____

TYPE OF INFORMATION TO BE RELEASED (no information will be released unless box is checked)

General records (excluding protected records) (limited to 3 yrs, including lab/xray reported unless otherwise stated)	From _____ To _____
Immunization Records only	ALL ON FILE
Physical Exam for School / Sports	From _____ To _____
Other (please specify)	From _____ To _____

INFORMATION PROTECTED BY STATE / FEDERAL LAW

❑ Drug/Alcohol abuse/treatment & diagnosis	From _____ To _____
❑ Sexually transmitted diseases	From _____ To _____
❑ Mental Health Treatment	From _____ To _____
❑ HIV/AIDS diagnosis/treatment/testing	From _____ To _____
❑ Genetic Testing Information	From _____ To _____

THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR, OR 90 DAYS AFTER IT IS SIGNED, UNLESS ANOTHER DATE OR EVENT IS ENTERED HERE: _____

This authorization provides that:

- I can cancel this authorization at any time by written notification to Albert S. Callie, MD, PC. , except if this practice has taken action relying on this consent. Information released according to the terms of this authorization cannot be recalled.
- Information used or disclosed pursuant of this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed
- I will receive a copy of this completed and signed authorization form _____.

SIGNATURE _____ DATE: _____

RELATIONSHIP TO PATIENT: _____