MEDICAL RECORDS RELEASE FORM

I hereby authorize (mark one):

___ _____

___ FPS Medical Center at 297 Lake Havasu Avenue, Suite 204 Lake Havasu City, AZ 86404

to disclose the following information from the health records of:

Patient name: _____ Date of Birth: _____

Phone Number:_____ SSN:_____

To be disclosed to: Dr. Jeffrey Carls, M.D. 1720 Mesquite Avenue, Suite 100 Lake Havasu City, AZ 86403 928-855-1550

Records to be disclosed to the above entity (please mark):

____` All medical records, images, documents, etc. from the date first seen at FPS Medical Center. Records to be sent in an electronic, CCDA format compatible with Nextgen Share.

____ Other: (specify)_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released, all EXCEPT:

_____Drug/Alcohol abuse/ treatment & diagnosis _____Sexually transmitted diseases

_____HIV/AIDS treatment and testing _____Mental Illness or psychiatric diagnosis/treatment

For the purpose of : _____continuing treatment _____transferring care ____Other (specify):_____

FOR YOUR INFORMATION:

- This authorization for Dr. Jeff Carls shall be in force for **90 days**, unless otherwise specified by the patient, at which time this authorization to use or disclose this protected health information expires.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Jeff Carls at 1720 Mesquite Avenue Suite #100 Lake Havasu City, AZ 86403. I understand that a revocation is not effective to the extent of FPS Medical Center has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- Dr. Jeff Carls will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure.

_____ _____

Signature of Patient **Date**