Arizona Community Physicians P.C.
Authorization to Release Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____Birth Date_____ Email _____

INFORMATION TO BE RELEASED FROM

☐ ACP Northwest Imaging
2191 W Orange Grove Rd.
Tucson, AZ 85741
Phone: (520) 547-3940

☐ ACP Eastside Imaging
5515 East 5th Street
Tucson, AZ 85711
Phone: (520) 298-1138

INFORMATION TO BE RELEASED TO

Name of Physician/Organization/Individual_____

Street Address _____

City/State/Zip_____

Phone _____ Fax_____ Email _____

Requested format: ☐ Paper (Reports Only) Delivery method: ☐Mailed to address above. ☐Pickup at selected imaging center

☐ Digital Images (Includes Reports and Images) Delivery method: ☐Email to above email ☐ Fax to above number

TYPE OF INFORMATION TO BE RELEASED (Box must be checked and information provided)

☐ Specific images and reports (Prior studies/ Todays exam(s))

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____

General Imaging Release

☐ All study images and reports (requesting multiple dates of service)
(This will be limited to 1 year of information unless otherwise indicated)

DATES OF TREATMENT
From_____ To_____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

Signature of Patient or Personal Representative who may request Release of Medical Information: I hereby authorize the release of the above indicated medical information. I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____ _____

Signature of Patient OR Legal Representative **Date** **Please Print Name of Signing Party**

MR use only Date request received___/___/___ Date request completed ___/___/____ Completed by _____

Form 100-Authorization to Release Medical Records (Imaging specific)
Revised: 7/11/2025