

**Records Request Portal Opt-Out Form**

Complete this form to opt out of having your records transmitted through the DES/DDD Records Request portal. Ensure all fields are complete. Legally authorized representatives must provide a signature at the bottom.

Complete all fields below and check the box that says, "Opt Out." Sign the form and return it to the DDD Records Management Unit via email, fax, or mail:

**Phone:** (602) 774-5221

**Fax:** (602) 807-5001

**Mail:** ATTN DDD RECORDS, 2455 S 7th St, Phoenix, AZ 85034

**Email:** [DDDRecordsRequest@azdes.gov](mailto:DDDRecordsRequest@azdes.gov)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (Number, Street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**Opt Out:** I do not want my health information shared through the Records Request portal.

Signature of member or member's Parent/Guardian/Healthcare Decision Maker:

\_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Indicate your authority to sign if signed by someone other than the member (check one):

Parent/Guardian

Caregiver with authority to make healthcare decisions

This authorization shall be in force and in effect for one year from the date of execution at which time this authorization expires.

A separate form must be completed for each member if you are signing on behalf of more than one member (such as your children).

By signing above, I confirm that I am the individual named above or their legally authorized representative. I understand that opting out means my records will not be transmitted through the Records Request portal.

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