AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SS#_____
Address: _____ City _____State _____ Zip_____
Telephone Number: _____ Alternate Number: _____
Records being requested:

- ☐ All medical records
- ☐ Records from dates: _____ to _____

Purpose for this request: _____

Please Check One:

☐ I would like _____
Address: _____
City: _____ State: _____ Zip _____

to release my records to: **Arizona Spine Consultants**
9250 N. 3rd St. Ste, 2020
Phoenix, AZ 85020
Phone: 602-242-6500 Fax: 602-242-6600

☐ I would like **Arizona Spine Consultants** to release my records to:
Name: _____
Address: _____
City: _____ State: _____ Zip _____

I understand information within my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It also may include information about behavior or mental health services or treatments for alcohol and drug abuse. I understand any disclosures of information carries with it the potential for re-disclosure and may not be protected by federal confidentiality rules. I understand authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization and I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand records sent directly to physicians or healthcare facilities for continuity of care will be completed free of charge. Records provided to patients or other entities will be charged a duplication fee of $.10 per page after the first 10 pages. After 80 pages, a professional fee of $15 + an additional $.10 per page will apply. I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand I have the right to revoke this authorization at any time. My revocation must be in writing and will not apply to information already based on this authorization. ******Unless otherwise revoked, this authorization will expire in six months unless I request the expiration to begin on this date: _____.**

_____ _____

Signature of Patient Date

_____

Signature of Parent/Legal Guardian

Rev. 10/11/2018