AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _______________________________ DOB: ________________
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 ________________
Phone: ________________________________Fax: ______________________________

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 ______________
Phone: ________________________________Fax: ______________________________

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

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Signature of Parent/Legal Guardian

Rev. 02.04.2019