Authorization to Disclose Heath Information

Central Phoenix Medical Clinic & Clinical Research Advantage

I, the undersigned, authorize:

Central Phoenix Medical Clinic, LLC
7600 N 15th St. Ste 190
Phoenix, AZ 85020
Phone: 602-200-3800 Fax: 602-200-3838

Patient Information:

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address:_____ Date of Birth: _____

City: _____ State: _____ Zip:_____ Phone Number: _____

Release Information To or From (circle):

-This box must be complete in order for the request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip:_____ Fax Number: _____

Purpose of Request: □ Personal □ Treatment □ Legal □ Insurance □ Disability
□ Transfer/Reason _____ □ Other_____

Information to be Released:

Section 1:

For personal requests, there will be a $15 flat fee and $0.25 per page fee for all requests on paper(plus the cost of postage and envelope) or there will be a $10 flat fee and a $0.25 per page fee for all requests on CD (plus the cost of postage and envelope). Please be specific in the information you would like in Section 2:

For doctor to doctor requests, there will be no fee. By default, the past two years of pertinent information will be sent. Please provide any specific additional information in Section 2:

Section 2:

Please provide information in my medical record for dates:

From_____To_____

- □ History and Physical Examination
- □ Office Visit Note
- □ Laboratory Tests
- □ X-Rays/Imaging Reports
- □ Other_____

Form of Records:

Please Choose:

□ Records on Paper

□ Records on CD ----------> 4 Digit Encryption Key: _____

*If no encryption key is provided, encryption key will be included with CD upon delivery.

Authorization to Release Protected:

*Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check One	*Initial Each Line Below*
I □ DO	□ **DO NOT** want information on ***Mental Health** to be released	_____
I □ DO	□ **DO NOT** want information on ***HIV tests & Related information** to be released	_____
I □ DO	□ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I □ DO	□ **DO NOT** want information about ***Communicable Diseases** released	_____

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request

Patient's Signature_____ **Date:**_____

(Required for all patients 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____ **Date:**_____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

-This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.

-I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.

-I understand that my treatment or continued treatment by Central Phoenix Medical Clinic, LLC and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

-I understand that I may inspect or copy the information that is used or disclosed.