In order to increase privacy and security for our patients, we have relinquished Release of Information and HIPAA Compliance concerning Records Disclosure duties to American Medical Solutions. Please forward ALL questions or concerns to 602-997-7041.

AUTHORIZATION FOR RELEASE OF INFORMATION
(Release must be filled out completely in order for records to be released.)

I hereby authorize my healthcare provider to disclose any and all parts of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ('HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, (except for psychotherapy notes) chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations

____________________________ __________________ _________________________

Print Patient Name **Date of Birth** **Social Security Number**

Description of information to be released: Any and all documents for the time frame listed below.

All_______ **OR** 2 Years_______ **OR** 5 Years_______ **OR** Timeframe: From ________ To_________
If billing is requested please check here: Billing ______

If no option is selected 2 years of medical information will be released

Purpose of the use and/or disclosure: At the request of the individual

The health information described shall be released TO:

____

Name **Address** **City** **State** **Zip**

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until ______________________________.
Expiration event/ date

I understand that I may revoke this authorization at any time by notifying my physician in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

__________________________________ _____________________________________

Signature of Patient **Date**
Patient phone:______________________________
Patient address:____

If you are not the patient:
*What is your relationship to the patient?____
*If you are the patient's healthcare decision maker, please provide a <u>**Medical**</u> **Power of Attorney**.
*If the patient is deceased and you are the personal representative of the patient's estate, please attach evidence (e.g. Death Certificate).

IT IS UNDERSTOOD THAT THERE MAY BE A FEE FOR OBTAINING THESE RECORDS.