AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME: ____ DOB: __________________________________

THE ABOVE LISTED PATIENT AUTHORIZES THE FOLLOWING HEALTHCARE FACILITY TO MAKE RECORD DISCLOSURE:

FACILITY NAME: ____

FACILTY PHONE: ____ FACILITY FAX: ___________________________

AZ REGIONAL	480-223-4035	CHANDLER REGIONAL	480-728-3980
BANNER DESERT	480-412-8777	GILBERT HOSPITAL	480-840-3795
BANNER BAYWOOD	480-321-4179	MERCY GILBERT	480-728-9618
BANNER GATEWAY	480-543-2252	MOUNTAIN VISTA	480-358-6407
BANNER GOOD SAM	602-839-6150	SCOTTSDALE OSBORNE	480-882-4377
CARDON CHILDRENS	480-512-4898	ST. JOSEPH'S	602-406-4120

PURPOSE OF DISCLOSURE IS:

_______CHANGE OF INSURANCE OR PHYSICIAN

___✖___CONTINUATION OF CARE

_______OTHER

TYPES OF INFORMATION TO DISCLOSE:

___✖___MOST RECENT 2 YEARS OF RECORDS

_______DATES/OTHER

_______SPECIFIC INFORMATION_____________

RESTRICTIONS: ONLY MEDICAL RECORDS ORIGINATED THROUGH THIS HEALTHCARE FACILITY WILL BE COPIED UNLESS OTHERWISE REQUESTED. THIS AUTHORIZATION IS VALID ONLY FOR THE RELEASE OF MEDICAL INFORMATION DATED PRIOR TO AND INCLUDING THE DATE OF THIS AUTHORIZATION UNLESS OTHER DATES ARE SPECIFIED.

I UNDERSTAND THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATIONG TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICE, AND TRATEMENT FOR ALCOHOL AND DRUG ABUSE.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

RELEASE TO: ***HOMEWOOD FAMILY MEDICINE*** ADDRESS: ***4540 E. BASELINE RD. #113 MESA, AZ 85206***

PHONE: **480-558-4700** FAX: **480-558-1936**

_______PLEASE MAIL RECORDS

___✖___PLEASE FAX RECORDS

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE HEALTH INFORMATION MANAGEMENT DEPARTMENT. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY. **UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: _______________. IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT OR CONDITION, THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM THE DATE SIGNED.** I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND THAT I MAY INSPECT OR OBTAIN A COPY OF THE INFORMATION TO BE USED OR DISCLOSED, AS PROVIDED IN CFR 164.524. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE QUESTIONS ABOUT DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE AUTHORIZED INDIVIDUAL OR ORGANIZATION MAKING DISCLOSURE.

I HAVE READ THE ABOVE FOREGOING AUTHORIZATION FOR RELEASE OF INFORMATION AND DO HEREBY ACKNOWLEDGE THAT I AM FAMILIAR WITH AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THIS AUTHORIZATION.

_____________________________________ _____________________________________

SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE

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PRINTED NAME OF PATIENT/PARENT OR GUARDIAN