AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: Date of Birth:

MEDICAL RECORDS RELEASE

Records to be sent (TO / FROM) the following facility:

Individual/Hospital/Office:

Address:

City: State: Zip Code:

Phone: Fax:

REQUEST FOR RECORDS

Records to be released (TO / FROM):

Arizona Center for Pain Relief
9015 E. Pima Center Parkway, Suite 1r
Scottsdale, AZ 85258
Phone: 480-291-6440
Fax: 480-291-6441

Information to be released:

- ☐ Complete Medical Records
- ☐ Clinical Notes
- ☐ Procedure Notes
- ☐ Imaging Reports
- ☐ From Date: / / To Date: / /
- ☐ All dates of treatment
- ☐ Other:

I have carefully read this consent, understand its contents and voluntarily authorize the release, disclosure and use of the above mentioned medical records. I understand that this information is for use by Arizona Center for Pain Relief only. The confidentiality of this information is protected by federal law and the HIPAA privacy rule. I also understand that my information in my health records may include information relating to sexually transmitted disease, acquire immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health diagnoses and services as well as treatment for alcohol and drug use. The information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal law. I understand that I may revoke this authorization in writing at any time and that I can also refuse to sign this authorization. I am entitled to inspect and obtain a copy of the information being disclosed (pursuant to CFR 164.524). Lastly, a photocopy of this authorization shall be considered as effective and valid as the original and I understand that any disclosure of information may not be protected by federal confidentially rules.

Signature of Patient or Legal Representative **Date**

Witness *(office use only)* **Date**