SCOTTSDALE HEALTHCARE℠

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

□ 16101 N. 82nd Street, Ste. A-8
Scottsdale, AZ 85260
Phone: (480) 323-1880
Fax: (480) 905-1136

□3501 N. Scottsdale Road, Ste. 231
Scottsdale, AZ 85251
Phone: (480)882-4770
Fax: (480) 882-4391

□10200 N. 92nd St., Ste. 102
Scottsdale, AZ 85258
Phone: (480) 323-3818
Fax: (480) 323-3238

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1. PATIENT IDENTIFYING INFORMATION:
Patient Name: _____Date of Birth:_____
Address:_____ City: _____ State: _____ Zip Code: _____
Phone number:_____ Date(s) of service(s):_____

A. Release of medical records FROM Scottsdale Healthcare:
I authorize SCOTTSDALE HEALTHCARE OCCUPATIONAL HEALTH DEPARTMENT to release my medical records as I have indicated in ***Section 2***. below:
Disclose to:_____
Address:_____
Phone Number:_____ FAX ***(continuing care reasons only)***_____

B. Release of records from ANOTHER HEALTHCARE PROVIDER to Scottsdale Healthcare:
I authorize _____ to release my medical records to SCOTTSDALE HEALTHCARE OCCUPATIONAL HEALTH DEPARTMENT as I have indicated in ***Section 2***.below*. Note: Please mail records to the Scottsdale Healthcare facility indicated above* or FAX *to:*_____

2. SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED (*check all that apply):*
_____ Drug Screen Results_____ Immunization Record _____ Lab Tests
_____ X-Ray Reports _____ Progress Notes _____ Entire Record _____ Pertinent Records Only
Other (specify) _____

Specific description of the purposes of the disclosure:
_____ Continued Patient Care _____ Employment_____ Personal Records

I authorize the provider to use or disclose information related to:
_____ AIDS/HIV and other Communicable Diseases _____ Genetic Testing Information
_____ Psychiatric Care Reports _____ Alcohol and/or Drug Abuse Treatment

I understand that Scottsdale Healthcare will not condition treatment on my signing this authorization. Scottsdale Healthcare will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read Scottsdale Healthcare's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the Scottsdale Healthcare. Unless I *revoke* the authorization earlier, it will expire upon its completion or *90 days* from date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be *re-disclosed* by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Date

Relationship to Patient or Description, Or Authority to Act for Patient