



**AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize use or discloser of the named individuals health information as described below:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

**Records sent directly to providers or healthcare facilities will be done free of charge. Records given directly to patients or other entities will be charged a duplication fee- see attached price list.**

**Records being sent to another provider for urgent medical treatment will be completed immediately, all other requests will be handled within 15 days from the date of this request.**

Check one:

\_\_\_\_\_ I would like Camelback Women's Health to disclose my records to: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ I would like \_\_\_\_\_ Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ to release my medical records to Camelback Women's Health.

\_\_\_\_\_ Tatum Office: 11209 North Tatum Blvd, Suite 255 Phoenix, AZ 85028 602-494-5050 fax: 602-494-2611

\_\_\_\_\_ Camelback Office: 4530 North 32<sup>nd</sup> Street, Suite 100 Phoenix, AZ 85016 602-468-3912 fax: 602-840-0062

Dates of Treatment Requested: \_\_\_\_\_

Purpose of Request: \_\_\_\_\_

I understand that the information in my record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It also may include information about behavior or mental health services or treatments for alcohol and drug abuse.

I understand any disclosure of information carries with it the potential for re-disclosure and the information then may not be protected by federal confidentiality rules.

I understand I have the right to revoke this authorization at any time. My revocation must be in writing and will not apply to information already based on this authorization.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand I may inspect or obtain a copy of the information to be used or disclosed.

Unless otherwise revoked, this authorization will expire in six months unless I request the expiration to begin on this date: \_\_\_\_\_.

Signature of Patient

Date:

Signature of Patient Guardian

Relationship