Camelback
Women's Health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB: ______________ SS# ____________________

Address: ____ City _______________ State ______ Zip___________

Telephone Number: ____________________________________ Alternate Number: __________________________________

Records being requested: ❒ All medical records ❒ Records from dates: ____________________ to _____________________.

Purpose for this request: ____

Please Check One:

❒ I would like ____ Phone: ____________________

Address: ____

City: ________________________________ State: _______ Zip __________

to release my records to: **Camelback Women's Health**

Attn: Medical Records Dept.
11209 N Tatum Blvd, Suite 255
Phoenix, AZ 85028
Phone: 602-494-5050 Fax: 866-777-2251

❒ I would like **Camelback Women's Health** to release my records to:

Name: ____ Phone: ____________________

Address: ____

City: __________________________________ State: _____ Zip _________

❒ I am requesting a personal copy of my medical records and understand there is fee to cover the cost of photocopying.

I understand information within my medical 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 disclosures of information carries with it the potential for re-disclosure and may not be protected by federal confidentiality rules.

I understand authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization and 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 records sent directly to physicians or healthcare facilities for continuity of care will be completed free of charge. Records provided to patients or other entities will be charged a duplication fee of $.10 per page after the first 10 pages. After 80 pages, a professional fee of $15 + an additional $.10 per page will apply. I understand I may inspect or obtain a copy of the information to be used or disclosed.

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. ****__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 Parent/Legal Guardian