SCOTTSDALE HEALTHCARE®

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

❑ **Scottsdale Healthcare Osborn**
Health Information Management
7301 East Fourth St.
Scottsdale, AZ 85251-6403
(480) 882-4040
FAX: (480) 882-4377

❑ **Scottsdale Healthcare Shea**
Health Information Management
9003 Shea Blvd.
Scottsdale, AZ 85260
(480) 323-3213
FAX: (480) 323-3116

❑ **Scottsdale Healthcare Thompson Peak**
Health Information Management
7400 E. Thompson Peak Pkwy
Scottsdale, AZ 85255
(480) 324-7060
FAX: (480) 324-7072

1. PATIENT IDENTIFYING INFORMATION:

Patient Name: _____ Date of Birth:_____

Address:_____ City: _____ State: _____ Zip Code: _____

Phone number:_____ Date(s) of service(s):_____

A. <u>Release of medical records FROM Scottsdale Healthcare</u>:

I authorize SCOTTSDALE HEALTHCARE to release my medical records as I have indicated in ***Section 2***. below:

Disclose to:_____

Address:_____

Phone Number:_____ FAX ***(continuing care reasons only)***_____

B. <u>Release of records from ANOTHER HEALTHCARE PROVIDER to Scottsdale Healthcare:</u>

I authorize _____ to release my medical records to SCOTTSDALE HEALTHCARE 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):*

_____ Discharge Summary _____ History and Physical Exam _____ Operative Reports _____ EKG
_____ X-Ray Reports _____ Lab Tests _____ Consultations _____ Entire Record
_____ Pertinent Records Only Other (specify) _____

Specific description of the purposes of the disclosure:

_____ Continued Patient Care _____ Workers' Compensation _____ Insurance/Payment of Care
_____ The disclosure is at the patient's request. _____ Other (specify)_____

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 Relationship to Patient or Description Or Authority to Act for Patient

FOR OFFICIAL USE ONLY:
Acct#_____
How Sent_____
Initials:_____ **Date:**_____ **Time:**_____


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