ARIZONA ADVANCED SURGERY

Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Telephone: _____

I authorize **Arizona Advanced Surgery** or other person/entity _____ to disclose/release the following information:

_____ All medical records related to (specify condition, treatment, etc.): _____

_____ All billing records related to (specify condition, treatment, etc.): _____

_____ Specific records/information as follows: _____

_____

Purpose of disclosure: _____

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

Release information TO:

Address: _____

_____

_____

Telephone: _____ **Fax:** _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Address

_____ _____

Description of Personal Representative's Authority Telephone

This authorization expires (1) one year from date signed