# Authorization to Disclose Health Information

ARIZONA CENTER FOR Hand to Shoulder Surgery

I, the undersigned, authorize:

to release my health information as noted below:

Please return the **COMPLETED** authorization to this address

Arizona Center for Hand to Shoulder Surgery
370 E. Virginia Ave. #100, Phx Az 85004
2111 W. University Dr. Mesa AZ 85201 Phone: 602-258-4788 Fax: 602-258-5131

## Patient Information:

***All sections must be completed in order for request to be processed***

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address:_____ Date of Birth: _____

City: _____ State: _____ Zip:_____ Phone Number: _____

## Release Information To:

*-This section must be complete in order for the request to be processed-*

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip:_____ Fax Number: _____

Purpose of Request: □ Personal □ Treatment □ Legal □ Insurance □ Disability
□ Transfer/Reason _____ □ Other_____

## Payment Information for Personal Use

*** PAYMENT OPTIONS: Check, Credit Card or Money Order

Charges outlined below will be applied for all copies released directly to patient or sent on patient behalf.

***Invoice must be paid before records will be released**

A.R.S 12-2295: **A Except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records or payment records a reasonable fee for the production of the records. Except as necessary for continuity of care, a health care provider or contractor may require the payment of any fees in advance.**

**$15 per request - plus $0.25 per page Postage & Envelope Cost Xray on Disc $25.00**

## Information to be Released:

Section 2:
Please provide information in my medical record for dates: Please specify dates:
From_____To_____

- □ History and Physical Examination
- □ Office Visit Note
- □ Laboratory Tests
- □ X-Rays/Imaging Reports
- □ Other_____

## Form of Records:

Please Choose:

□ Records on Paper

□ Records on CD ----------> 4 Digit Encryption Key: _____

*If no encryption key is provided, encryption key will be included with CD upon delivery.

## Authorization to Release Protected:

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

| | *Check One* | *Initial Each Line Below* |
|---|---|---|
| **I □ DO** | □ **DO NOT** want information on ***Mental Health** to be released | _____ |
| **I □ DO** | □ **DO NOT** want information on ***HIV tests & Related information** to be released | _____ |
| **I □ DO** | □ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released | _____ |
| **I □ DO** | □ **DO NOT** want information about ***Communicable Diseases** released | _____ |

STOP

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request

**Patient's Signature**_____ **Date:**_____

(Required for all patients 18 years and older for psychiatric records, 14 years and older for substance use records)

**Signature of Parent or Legal Guardian**_____ **Date:**_____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

*-This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*

*-I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*

*-I understand that my treatment or continued treatment by Arizona Center for Hand Surgery and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*

*-I understand that I may inspect or copy the information that is used or disclosed.*