Authorization to Disclose Health Information

Desert View Family Medicine

I, the undersigned, authorize Desert View Family Medicine to release my health information as noted below.

Please return this **COMPLETED** authorization form to your Physician's Office.

Desert View Family Medicine
2730 S. Val Vista Dr. Ste 187
Gilbert, AZ 85295
p: 480-324-0300
f: 480-324-0324

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: _____

Examples: Continuation of Care, Legal, Insurance, Patient Personal Use, Other (please explain).

Payment Information for Personal Use

PAYMENT OPTIONS: Check, Credit Card or Money Order. No FEE for Doctor to Doctor requests. Charges outlined below will be applied for all copies released directly to patient or sent on patient's behalf.

Invoice must be paid before records will be released

A.R.S 12-2295: Except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of their medical records or billing 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.

****By Default, the past 2 years of pertinent information will be sent****

Information to be Released:

Please provide information for my medical or billing records for the following dates of service:
From_____To_____

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

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	_____

Please confirm that you have placed a checkmark and you have 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 person authorizing this disclosure is not the parent, legal representation documentation must be supplied)

-This authorization will expire 90 days from the date appearing above. I understand I may revoke this authorization at any time by notifying the Health Information Management Department in writing. If I revoke this authorization, there will be no effect on the actions the hospital took before receiving the revocation.

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

-I understand that my treatment or continued treatment by Desert View Family Medicine and its affiliates is no way conditioned on whether or not I sign the authorization. I understand I may refuse to sign the authorization at any time.

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