Phoenix Orthopaedic Consultants

Authorization to Disclose Health Information

I, the undersigned, authorize

Phoenix Orthopaedic Consultants
19636 N. 27th Ave, Suite 401 * Phoenix, AZ 85027
Phone: 602.298.8888 * Fax: 602.978.4129

Patient Full Name: ______________________________ Date of Birth: ____________________

Patient Address: ____

City: ____________________ State: ________ Zip: _________ Phone Number: ____________________

Release Information To or From: (please circle one):

Name \ Facility: ______________________________ Attention: ____________________

Address: ______________________________ Fax Number: ____________________

City: ____________________ State: ________ Zip: _________ Phone Number: ____________________

Purpose of Request: ☐ Disability ☐ Legal ☐ Personal ☐ Transfer ☐ Other ____________________

Dates to release: From______________ To ______________ ☐ Office Visit Notes ☐ X-ray Images

Form of Records:

For any requests other than personal or transfer of care there is a fee that must be paid prior to the records being sent. The options are listed below.

Please choose how you would like to receive your records:

- ☐ Secure email via Med Tunnel = $40.00 flat fee for all records, X-rays included
- ☐ Fax, Mail (Paper) = $40.00 flat fee for all records, X-rays included
  - Fax Number: ______________________________ Attention: ____________________
  - Mailing Address: ____
- ☐ CD = $40.00 flat fee for all records, X-rays included
- ☐ X-rays only (paper or cd) = $5.00 flat fee for all X-ray Images

Authorization to Release Protected Information:

Please complete the check boxes below indication how protected information should be handled even if the categories do not necessarily apply to the patients medical records.

I ☐ DO ☐ DO NOT want information on **Mental Health** to be released ______________

I ☐ DO ☐ DO NOT want information on **HIV tests and related information** to be released ______________

I ☐ DO ☐ DO NOT want information about **Alcohol and / or Substance Abuse** to be released ______________

I ☐ DO ☐ DO NOT want information about **Communicable Diseases** to be released ______________

* 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 practice took before I 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 by Phoenix Orthopaedic Consultants and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

____ ______________________________

Signature of Patient or Patients Personal Representative Date