ARIZONA ALLERGY ASSOCIATES

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8140 East Cactus Rd., #710, Scottsdale, AZ. 85260-5265 . 480-344-4460 . Fax 480-344-4465

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
(Medical Records Request)

I hereby authorize use or disclosure of the named individual's health information as described below:

_____ _____
Patient Name **Date of Birth**

_____ _____
Address (Street, Apt. #, City, State, Zip Code **Telephone Number**

The following individual or organization is authorized to make the disclosure:

☐ **Arizona Allergy Associates**

☐ **Other (please specify)** _____

Circle One: Mail/Pick up/Fax # _____

This information may be disclosed to and used by the following individual or organization:

☐ **Arizona Allergy Associates**

☐ **Other (please specify)** _____

Circle One: Mail/Pick up/Fax # _____

If records to be picked up, person authorized to pick up records: _____

Treatment Dates: _____

Purpose of Request: _____

The following information is to be disclosed: (Please check one box for <u>each</u> item.)

Yes	No	
☐	☐	**Physician Notes**
☐	☐	**Lab Results**
☐	☐	**X-Ray Results**
☐	☐	**Doctor's Dictation regarding patient**
☐	☐	**Complete Record**
☐	☐	**Other** _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

_____ _____
Signature of Patient or Legal Representative **Date**

Relationship to patient, if signed by legal representative _____

7-1-04