Authorization to Release Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PATIENT NAME: _____ DATE OF BIRTH:_____ACCOUNT #:_____

SECTION 1: **I hereby authorize Comprehensive Surgical Care to disclose/release (check all that apply):**

□ Operative Reports
□ Progress Notes
□ Laboratory Results
□ HIV Lab Results*
□ Medication Summary
□ Other (specify):_____

□ Immunization Record
□ Nursing Documentation
□ Photos
□ Billing/Payment Record
□ Correspondence

□ Diagnostic Imaging Report(s): _____
□ Diagnostic Images (on CD): _____

*Note HIV related information is not disclosed unless specifically authorized.

To the following person(s), facility, or entity: **From Service Date _____to _____**

_____
Name

_____ _____ _____
Phone # **Fax #** **Email**

_____
Address **City** **State** **Zip Code**

Method of Delivery (Check One): □ **Mail** □ **Fax** □ **Email** □ **Pick Up in Person (State issued ID required)**

This Authorization Expires (Check One): □ **1 year** □ **6 months** □ **Other:** _____

Purpose of Release (Check all that apply): □ **Personal** □ **Continuing Care** □ **Legal** □ **Other:** _____

I understand that after Comprehensive Surgical Care (CSC), the custodian of the records, discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked of specified, this authorization will expire 1 year from date of signature. *You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer 838 W Elliot Rd Suite 102 Gilbert, AZ 85233.*

_____ _____
Signature of Individual (Person whom the Information Relates) Date of Signature

– OR –

_____ _____
Signature of Patient Representative Date of Signature

_____ _____
Printed Name of Patient Representative Relationship to Patient

SECTION 2:

Medical Record Release

Authorization Verified By (Print) : _____ **Date of Release**:_____

□ All Items requested released □ Exceptions:_____

For Records Picked Up in Person:

I understand that after Comprehensive Surgical Care (CSC), the custodian of the records, discloses the requested information, it may no longer be protected by federal and/or state privacy laws. I acknowledge that I have received the records indicated above.

_____ _____ _____
Name of Individual Records Released To (Print) Signature Date

_____ _____
State/Federal ID # Witness Signature