



Scottsdale Healthcare Osborn Health Information Management 7301 East Fourth St. Scottsdale, AZ 85251-6403 (480) 882-4040 FAX: (480) 882-4377

Scottsdale Healthcare Shea Health Information Management 9003 Shea Blvd. Scottsdale, AZ 85260 (480) 323-3213 FAX: (480) 323-3116

Scottsdale Healthcare Thompson Peak Health Information Management 7400 E. Thompson Peak Pkwy Scottsdale, AZ 85255 (480) 324-7060 FAX: (480) 324-7072

1. PATIENT IDENTIFYING INFORMATION:

Patient Name: Date of Birth: Address: City: State: Zip Code: Phone number: Date(s) of service(s):

A. Release of medical records FROM Scottsdale Healthcare:

I authorize SCOTTSDALE HEALTHCARE to release my medical records as I have indicated in Section 2. below:

Disclose to: Address: Phone Number: FAX (continuing care reasons only)

B. Release of records from ANOTHER HEALTHCARE PROVIDER to Scottsdale Healthcare:

I authorize to release my medical records to SCOTTSDALE HEALTHCARE as I have indicated in Section 2. below. Note: Please mail records to the Scottsdale Healthcare facility indicated above or FAX to:

2. SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED (check all that apply):

Discharge Summary History and Physical Exam Operative Reports EKG X-Ray Reports Lab Tests Consultations Entire Record Pertinent Records Only Other (specify)

Specific description of the purposes of the disclosure:

Continued Patient Care Workers' Compensation Insurance/Payment of Care The disclosure is at the patient's request. Other (specify)

I authorize the provider to use or disclose information related to:

AIDS/HIV and other Communicable Diseases Genetic Testing Information Psychiatric Care Reports Alcohol and/or Drug Abuse Treatment

I understand that Scottsdale Healthcare will not condition treatment on my signing this authorization. Scottsdale Healthcare will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read Scottsdale Healthcare's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the Scottsdale Healthcare. Unless I revoke the authorization earlier, it will expire upon its completion or 90 days from date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient or Description Or Authority to Act for Patient



FOR OFFICIAL USE ONLY: Acct# How Sent Initials: Date: Time:



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