

Authorization To Release/Receive Medical Records

Patient:

I authorize:

Name

Scottsdale Psychological Assoc. Provider

Address

11000 N Scottsdale Road, Suite 163
Address

City State Zip

Scottsdale, Arizona 85254
City State Zip

Date of Birth

480-922-5440 480-922-5445
Phone Fax

_____ **To release and/or**

_____ **To receive**

information/records which may include protected health information under HIPAA. I request release of the following:

___ Billing and Scheduling ___ Protected Health Information ___ Verbal Communication

I am requesting my provider to release this information for the following reasons:

- ___ At the request of the individual (At the request of the individual is all that is required if you are my patient and you do not desire to state a specific purpose.)
- ___ To another health care provider for the purpose of obtaining health care.
- ___ Other, please specify: _____

The information should be release and/or received by:

Name of person/agency/institution

Address

City State Zip

Phone Fax

This authorization shall remain in effect for 12 months or until the date indicated here: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing person/agency address. However, your revocation will not be effective to the extent that the person/agency has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider generally may not condition health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

For the purpose hereof "Records" and/or "Information" shall include all confidential HIV related information (as defined in A.R.S. Section 36-661, confidential communicable disease related information (as defined in A.R.S. Section 36-661), and confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SEQ).

Signature of Patient

Date

Signature of Parent, Legal Guardian or Personal Representative, please indicate which

Date