

CONFIDENTIAL Authorization for Disclosure of Protected Health Information

(Medical Records Release)

Received in office by: _____ Date: _____

In order to provide for your healthcare, our practice collects information about your medical history, physical examinations, test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes not related to your treatment, receiving payment, or healthcare operations. This authorization gives our practice permission to disclose the elements of your protected health information listed below for the specified purposes to the stated recipient.

I understand that I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that there is a per page charge if I request records to be sent to myself. \$1.00 per page for the first 25 pages and then \$0.50 per page for additional pages plus postage.

Patient _____ (print) DOB: _____ SS # _____

Address _____

Therefore I, _____ (sign) consent to the disclosure of the following information:

- Dictated notes
- Office notes
- Fluorescein angiography
- Fundus photos
- MRI
- Lab reports
- Electrocardiograms
- Visual fields
- Telephone sheets
- Billing history
- All clinic records
- Other (specify)

List other facilities records to be included when releasing for the purpose of continuing medical care:

For the following dates: _____ Since _____ All _____

I hereby give special permission to release otherwise privileged information pertaining to the following:

- Mental Health
- Developmental disabilities
- Alcoholism
- AIDS Test results
- AIDS-Related disease diagnosis
- Drug abuse

Purpose or need for disclosure:

- At the request of the individual
- Payment of insurance claim
- Vocational rehabilitation evaluation
- Application for insurance
- Legal investigation
- Disability determination
- Further medical care
- Employer update

Release to: Dr. George Reiss
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Suite F101
Glendale, AZ 85306
Phone # 623-878-3939
Fax # 623-878-5567

Dr. Corey Batiste
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|-----------------------|
| Dr. approval _____ |
| Privacy officer _____ |
| Date _____ |

Records copied by: _____ Faxed or mailed by: _____ Date: _____