Medical Records
Phone: (480) 641-5400
Fax: (480) 218-4353

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Name:_____ Previous Name (If Applicable)_____

   Address: _____City:_____State: ____Zip Code: _____

   Phone#:_____Date of Birth: ____/____/____SSN:_____ CVAM Medical Record#:_____

I authorize CVAM to: Request / Release (*Circle One*)
Healthcare Information of the patient named above from / to:

2. Name (Physician/Hospital/Family Member/Self)_____

   Address: _____Suite#:_____

   City: _____State:_____Zip Code: _____

   Phone#:_____Fax#: _____

   For the purpose of: _____

   Preferred Format: Paper / Electronic CD (*Circle One*)

3. **The type and amount of information to be disclosed is as follows (*specify dates where appropriate)***
   - Complete Medical Record
   - Complete Medical Record from date, _____to date_____
   - Laboratory Results from date, _____to date_____
   - Billing Information_____
   - Other_____

4. **I understand that the medical information released by this authorization may include confidential information concerning treatment of physical and/or mental illness, alcohol/drug abuse, HIV/AIDS and past medical history.**

5. **I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.**

6. **I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. CVAM cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.**

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Patient or Personal Representatives Name (print) and Relationship Date
(Please attach applicable legal documentation of authority)

FOR OFFICE USE ONLY:

Photo ID Verified by: _____ _____
Name Date