

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