

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ MRN \_\_\_\_\_

1. I authorize the use and disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:  
**Arizona Spine & Joint Hospital**  
**4620 E. Baseline Road**  
**Mesa, AZ 85206**

\_\_\_\_\_  
This information may be obtained from or disclosed to the following individual or organization:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

For the purpose of: Further Medical Care Disability Legal Personal Use Insurance

\_\_\_\_\_  
The type and amount of information to be disclosed is as follows: (include dates where appropriate)

- Complete Medical Record
- Pertinent Medical Record Information
- Consultation (indicate physician)
  1. \_\_\_\_\_
  2. \_\_\_\_\_
- History & Physical
- Discharge Summary
- Operative report
- Radiology
- Lab
- Other \_\_\_\_\_

I do  I do not authorize the "facsimile transmittal" of health information.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Arizona Spine & Joint Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire automatically six (6) months from the date on which it was signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness