AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name_____Birth Date_____

1. I authorize the use and disclosure of named individuals's health information as described below.
2. The following organization is authorized to make the disclosure:

Desert Spine and Sports Physicians
3700 N. 24th Street Suite 210
Phoenix, AZ 85016
Phone: 602-840-0681
Fax: 602-957-1570

Desert Spine and Sports Physicians
6634 E. Baseline Rd. Suite 101
Mesa, AZ 85206
Phone: 480-361-5926
Fax: 602-957-1570

This information may be obtained from____ or disclosed to____ the following individual or organization:

Name/Facility:_____Attention:_____
Address:_____ City:_____ State:_____
Zip Code:_____
Telephone: (____)_____ Fax: (___)_____

For the purpose of: ___Further Medical Care ___Disability ___Legal ___Personal Use ___Insurance

___Please mail my records ___Please fax my records

Information to be released:
___ Complete Medical Records
___ Clinic Notes
___ Procedures Notes
___ Imaging Reports
___ Other _____Dates of Treatment

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health services, and treatment for alcohol and drug use. I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Desert Spine and Sports Physicians. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent 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 1 year 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 may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
Signature of Witness