Arizona Center for Chest Diseases

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Other Name: ______________________

Address: ______________________ Birth date: ______________________

______________________ Soc. Sec. No.: ______________________

______________________ Phone(Day): ______________________

I hereby authorize ____

____

____

to release a copy of the following information:

____

to:

Arizona Center for Chest Diseases
5090 N 40th Street, Suite 122
Phoenix, Arizona 85018
Phone (602)264 -5685 Fax: (602)631-9870

☐ For the following purposes: ______________________________
☐ At my request

Medical Records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.
I ☐ do ☐ do not authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon
- Treatment will not be continued on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

______________________________ ______________________________

Patient or Personal Representative's Signature Date

Description of Representative's Authority to Act for Patient

This Authorization will expire on ______________________ (list date or event)