

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____ hereby voluntarily authorize the disclosure of information from my health record.
Name of Patient

II. The information is to be disclosed by: Care Physicians Arizona, P.C., 8360 E. Raintree Drive, Ste 120, Scottsdale, AZ 85260.

And is to be provided to:

- Lapband Solutions, 10751 N. Frank Lloyd Wright Blvd., Suite B-106, Scottsdale, AZ 85259 Dr. Greg Robertson, 5240 E. Knight Dr., Suite 118, Tucson, AZ 85712
 Dr. Shawn Stevenson, 1100 S. Dobson Road, Suite 204, Chandler, AZ 85286

Other – Please Provide:

Name & Address of Primary Care Physician:

Name & Address of Person/Organization/Facility:

III. The purpose or need for this disclosure is:

- Further Medical Care Attorney School Research
 Personal Use Insurance Disability Other (Specify) _____

IV. The Information to be disclosed from my health record: (check appropriate box(es))

- Entire Record including medical records prepared at Care Physicians Arizona, P.C. and those medical records received at Care Physicians Arizona, P.C. from external healthcare providers, including but not limited to records related to laboratory services, Sleep Study services, _____
 Only information related to (specify) _____

 Only the period of events from _____ to _____
 Other (specify)(CHS, Billing, etc.) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment
 Sexually Transmitted Diseases Mental Health (Other than Psychotherapy Notes)
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Custodian of Medical Records, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining Insurance coverage or a policy of Insurance, other law may provide the Insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date)

I understand that Care Physicians Arizona, P.C. will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) Research related or (2) Provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45-CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

PATIENT IDENTIFICATION	NAME (Last, First, MI)
	ADDRESS
	CITY/STATE
	DATE OF BIRTH

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)

Date

SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark):

Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5USC 552a (i)(3)).