



Authorization to Release Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PATIENT NAME: _____ DATE OF BIRTH: _____ ACCOUNT #: _____

SECTION 1: I hereby authorize Comprehensive Surgical Care to disclose/release (check all that apply):

- Operative Reports
- Progress Notes
- Laboratory Results
- HIV Lab Results*
- Medication Summary
- Other (specify): _____
- Immunization Record
- Nursing Documentation
- Photos
- Billing/Payment Record
- Correspondence
- Diagnostic Imaging Report(s): _____
- Diagnostic Images (on CD): _____

*Note HIV related information is not disclosed unless specifically authorized.

To the following person(s), facility, or entity: _____ From Service Date _____ to _____

Name			
Phone #	Fax #	Email	
Address	City	State	Zip Code

- Method of Delivery (Check One):** Mail Fax Email Pick Up in Person (State issued ID required)
- This Authorization Expires (Check One):** 1 year 6 months Other: _____
- Purpose of Release (Check all that apply):** Personal Continuing Care Legal Other: _____

I understand that after Comprehensive Surgical Care (CSC), the custodian of the records, discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked or specified, this authorization will expire 1 year from date of signature. *You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 8475 E Hartford DR STE 201, Scottsdale, AZ 85255.*

Signature of Individual (Person whom the Information Relates)	Date of Signature
– OR –	
Signature of Patient Representative	Date of Signature
Printed Name of Patient Representative	Relationship to Patient

SECTION 2: Medical Record Release

Authorization Verified By (Print) : _____ **Date of Release:** _____

All Items requested released Exceptions: _____

For Records Picked Up in Person:
I understand that after Comprehensive Surgical Care (CSC), the custodian of the records, discloses the requested information, it may no longer be protected by federal and/or state privacy laws. I acknowledge that I have received the records indicated above.

Name of Individual Records Released To (Print)	Signature	Date
State/Federal ID #	Witness Signature	