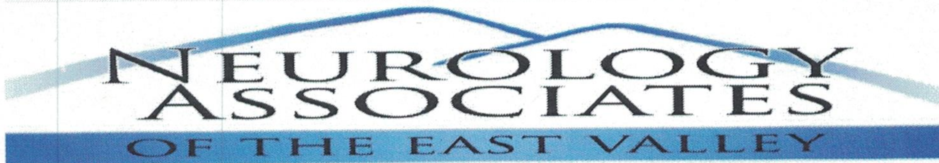

2201 W. Fairview St. Suite 1 Chandler, AZ 85224
Office: 480-800-4890 Fax: 480-427-4766

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: ______________________ Date of Birth: ______________________

Maiden Name: ______________________ Social Security #: ______________________

I request and authorize ____ to
Release/Obtain healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

Phone: ______________________ Fax: ______________________

Description of Protected Health Information to be disclosed:

□ Complete Medical Record
□ X-Ray Reports
□ Lab Tests
□ History and Physical Exam
□ Other ______________________

Purpose(s) of the disclosure:

□ Supplemental Care
□ Transfer of Care
□ Personal Use
□ Second Opinion
□ Workers' Compensation
□ Legal
□ Insurance Coverage or Payment of Care
□ Other ______________________

I hereby authorize Provider to release Protected Health Information ("Information") to **Neurology Associates of the East Valley, PLC**. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

____ ______________
Signature of the Patient or the Patient's Legal Representative Date

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.