# PARADISE VALLEY MEDICAL CLINIC, P.C.
## Authorization for Release of Protected Health Information

**Name:** _____ **Date of Birth:** _____
**Address:** _____ **Phone:** _____
_____

**Disclosing Entity:**
Paradise Valley Medical Clinic, PC ("PVMC")
9977 North 90th Street, Suite 180
Scottsdale, Arizona 85258
Ph: (480) 614-5800 Fax: (480) 614-6322

**Recipient:**
Physician/Facility: _____
Address: _____
_____
Phone: _____
Fax: _____

**Records Released:**
Date Range: _____
Type of Records: _____

**Purpose of Authorization:** _____

**Right to Revoke Authorization & Re-Release of Records:**
I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the attention of PVMC's Privacy Officer at PVMC's office located at 9977 North 90th Street, Suite 180, Scottsdale, Arizona 85258. I understand that my revocation will not be effective to the extent that PVMC has taken action in reliance on this Authorization.

I understand that neither PVMC nor the Recipient may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. In addition, I understand that the Recipient may redisclose the records and that the records may no longer be protected by the Federal privacy regulations.

This Authorization will automatically expire 90 days after the date of execution unless a different end date or event is specified herein: _____. A photocopy of this Authorization will be considered as effective and valid as the original.

**Drug/Alcohol, HIV, and Communicable Disease Information:**
I understand and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases, and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, the Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records that may be protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the Recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative

**Please do not fax records over 50 pages. Instead, send records over 50 pages by mail or CD. Thank you!**