Authorization for Release of Protected Health Information

Name:	Date of Birth:
Address:	Phone:
Disclosing Entity:	Recipient:
Physician/Facility:	
Address:	9977 North 90th Street, Suite 180
	Scottsdale, Arizona 85258
Phone:	Ph: (480) 614-5800 Fax: (480) 614-6322
Fax:	
Records Released:	
Date Range:	
Type of Records:	
Purpose of Authorization:	
Right to Revoke Authorization & Re-Release of Records:	zation, in writing, at any time by sending such written notification to the
that my revocation will not be effective to the extent that	d at I understand the Disclosing Entity has taken action in reliance on this Authorization.
that my revocation will not be effective to the extent that	the disclosing entity has taken action in reliance on this Authorization.
Lunderstand that neither the Disclosing Entity nor the R	ecipient may condition treatment, payment, enrollment, or eligibility for
	nd that as a covered entity, Recipient (i.e., PVMC) may only use or disclose
protected health information in accordance with applicat	
protected fleatiff information in accordance with applicat	ne law.
This Authorization will automatically expire 90 days after	er the date of execution unless a different end date or event is specified
	s Authorization will be considered as effective and valid as the original.
Drug/Alcohol, HIV, and Communicable Disease Informat	ion:
I understand and agree that the protected health inform	mation authorized to be disclosed under this Authorization may include
records for drug or alcohol abuse or psychiatric illness, ar	nd records of testing, diagnosis or treatment for HIV, HIV-related diseases
and communicable disease-related information.	
With respect to any communicable disease-related infor	rmation protected by State confidentiality rules and disclosed under this
· · · · · · · · · · · · · · · · · · ·	any further disclosure of this information unless further disclosure is
	n authorization or is otherwise permitted by applicable law.
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Further, with respect to any drug and alcohol abuse treat	ment information disclosed under this Authorization, this information has
· · · · · · · · · · · · · · · · · · ·	deral confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the
	closure of this information unless further disclosure is expressly permitted
- · ·	otherwise permitted by 42 C.F.R. Part 2. A general authorization for the
	for this purpose. The Federal rules restrict any use of the information to
criminally investigate or prosecute any alcohol or drug ab	
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!