AUTHORIZATION FOR RELEASE OF RECORDS

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PMB # 167
7650 S McClintock Drive #103
Tempe, Arizona 85284
Phone (480) 305-4300

PATIENT

NAME ______________________________ DATE OF BIRTH ______________

ADDRESS ____

PHONE ____________________ SECONDARY PHONE ____________________

PERMISSION TO RELEASE the following:

_______ all clinical sleep disorders information
_______ clinical sleep disorders information from most recent _______ months only
_______ psychology records (excludes psychotherapy notes)
_______psychotherapy notes or summary of psychotherapy
_______ billing records
_______ other (please specify) ______________________________
____
____

This information should be released to:

Name of Person/Agency/Institution ______________________________

Address ____________________ City ______________ State ____ Zip ______

Phone ______________________ Fax ______________________

This authorization shall remain in effect for 12 months or until the date indicated here: ____________

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing person/agency address. However, your revocation will not be effective to the extent that the person/agency has taken action in reliance on the authorization already given or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

- I understand that my provider generally may not condition health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

For the purpose hereof "Records" and/or "Information" shall include confidential HIV-related information (as defined in ARS Section 36-661, confidential communicable disease-related information (as defined in ARS Section 36-661) and confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SEQ).

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Parent/Legal Guardian/Personal Representative Date
(please circle correct term)