HealthyU Clinics
501 N 44th St, Suite 450,
Phoenix, AZ 85008
Phone: (602) 491-0703
Fax: (602) 894-8793

Authorization to Disclose Protected Health Information

Patient Information

Full Name: _____ Date of Birth: _____
Last *First* *Middle*

Other Names: _____

Address: _____

Phone: _____ Email: _____

HealthyU Clinics is Authorized to (*please select one*)

☐ Send my records to: ☐ Obtain my records from:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Information to be Released *If you fail to specify, only the past year will be provided.*

☐ Please release the last **1 year** of my records. ☐ Please release the last **2 years** of my records.

☐ **Specified date range:** _____ ☐ Please release **ALL** my records.

To Include:

☐ Progress Notes ☐ Radiology Reports ☐ Labs

☐ Operative Reports ☐ Consult Reports ☐ Discharge Summary

☐ Other: _____

Patient Rights and Authorization

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing and results, or AIDS information.

I understand this release of records is strictly voluntary. My treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization, except to take part in a research study. I may revoke this authorization at any time in writing, but such will not have effect on actions taken prior to receiving the revocation.

This authorization will expire in 90 days from the date signed, unless specified otherwise: _____

I understand that I may obtain a copy of the information described on this form for a reasonable copy fee, if I request it. I can request a copy of this form after I sign and date it.

_____

Patient or Authorized Party Signature **Date Signed**

_____

Printed Name of Authorized Party

Parents or Legal Guardians must sign for minors under the age 18. If patient is 18 or older but unable to sign, a copy of the legal documentation for patient's authorized party must be supplied along with this form.