Authorization to Disclose Health Information

UROLOGICAL ASSOCIATES of SOUTHERN ARIZONA, P.C.

I, the undersigned, authorize:

Urological Associates of Southern Arizona, P.C.:
- 6325 E. Tanque Verde Rd. Tucson, AZ 85715
Phone: (520)795-5830 Fax: (520)885-4469
- 2260 W. Orange Grove Rd, Tucson, AZ 85741
Phone: (520)742-9777 Fax: (520)742-7541

Patient Infomation

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ Other_____

Information to be Released

Section 1:

For personal requests, there will be a $15 flat fee and $0.25 per page fee for all requests on paper(plus the cost of postage and envelope) or there will be a $10 flat fee and a $0.25 per page fee for all requests above 20 pages on CD (plus the cost of postage and envelope). Please be specific in the information you would like in Section 2: →

For doctor to doctor requests, there will be no fee. By default, the past two years of pertinent information will be sent. Please provide any specific additional information in Section 2: →

Section 2:

Please provide information in my medical record for dates:

From_____**To**_____

☐ History and Physical Examination
☐ Office Visit Note
☐ Laboratory Tests
☐ X-Rays/Imaging Reports

Form of Records

Please choose:

☐ Records on Paper
☐ Records on a CD → 4 Digit Encryption Key:_____

*If no encryption key is provided, encryption key will be included with CD upon delivery.

Authorization to Release Protected

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check one		*Initial each line below*
I ☐ **DO**	☐ **DO NOT**	want information about ***Mental Health** released	_____
I ☐ **DO**	☐ **DO NOT**	want information about ***HIV Tests** & **Related Information** released	_____
I ☐ **DO**	☐ **DO NOT**	want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ **DO**	☐ **DO NOT**	want information about ***Communicable Diseases** released	_____

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____**Date:**_____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by* Urological Associates of Southern Arizona, P.C. *and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*