

Authorization to Disclose Health Information

I, the undersigned, authorize:

Foothills Neurology:

4530 East Muirwood Drive
 Suite 111 480-961-2365: Phone
 Phoenix, AZ 85048 480-961-2382: Fax

Stuart Hetrick, DO
 Pritish Pawar, MD PhD
 Scot Fechtel, MD
 Lauren Bowen, DO
 Padma Mahant, MD
 Eric Eross, DO

Timothy Visser, ND
 Melinda Preston, DNP
 Shuang Krus, DNP
 Mary Diedrich, DPT
 Susan Hawrylkiw, FNP
 Lisa Nelson, FNP

Lauren Siniscalchi, FNP
 Catherine O'Neill, FPN
 Amber McLouth, PA-C
 Kristin Plyer, PA-C
 Christin Simons, PA-C
 Jacob Whitney, PA-C

JoAnn Richi, LPC
 Ryan Ibarra, LAC
 McKenzie Millner, RDN

Patient Information

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

1. There will be a \$15.00 flat fee for all requests. There will be an additional \$0.25/page fee. Plus the cost of postage and envelopes. Complete Health Record

2. Please provide information in my medical record for dates: History and Physical Examination
 From _____ To _____ Office Visit Notes

3. Please check the boxes to the right for information being requested. Laboratory Tests
Consultation Reports
X-Rays/Imaging Reports

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

- | | | | |
|--------------------------|-----------|--|-------|
| <input type="checkbox"/> | DO | DO NOT want information about *Mental Health released | _____ |
| <input type="checkbox"/> | DO | DO NOT want information about *HIV Tests & Related Information released | _____ |
| <input type="checkbox"/> | DO | DO NOT want information about *Alcohol and/or Substance Abuse released | _____ |
| <input type="checkbox"/> | DO | DO NOT want information about *Communicable Diseases released | _____ |



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 Foothills Neurology 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.