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
- ☐ Padma Mahant, MD
- ☐ Melinda Preston, PsyNP
- ☐ Mary Diedrich, PT
- ☐ Amber McLouth, PA-C
- ☐ Scot Fechtel, MD
- ☐ Timothy Visser, ND
- ☐ Brigitte Lovell, DMD
- ☐ Susan Hawrylkiw, FNP
- ☐ Robin Adamson, PA-C

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

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.

2. Please provide information in my medical record for dates:
From_____ To_____

3. Please check the boxes to the right for information being requested. →

- ☐ Complete Health Record
- ☐ History and Physical Examination
- ☐ Office Visit Notes
- ☐ 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*
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 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.*

Rev. 08/10