Arizona Brain & Spine Center

Authorization for Release of Medical Records / Protected Health Information

Patient Information

Patient Name: _____

Date of Birth (DOB): _____

Phone Number: _____

Email Address: _____

Address: _____

City/State/ZIP: _____

Release Information

I hereby authorize Arizona Brain & Spine Center to release the following medical records as indicated below to:

Recipient Name/Practice: _____

Recipient Address: _____

Phone/Fax: _____

Records to be released (check all that apply)

[ ] Complete Medical Record

[ ] Office Visit Notes

[ ] Operative Reports

[ ] Other (specify)

Date Range: From _____ **To** _____

Purpose of Disclosure (check all that apply)

[ ] Continued Care/Referral

[ ] Personal Use

[ ] Insurance or Legal

[ ] Other

Expiration: Unless revoked in writing earlier, this authorization expires 12 months from the date of signature or on:

_____

Acknowledgment

I understand that: (1) I may revoke this authorization at any time by giving written notice to Arizona Brain & Spine Center, except to the extent that action has already been taken based on this authorization; (2) once information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA; (3) Arizona Brain & Spine Center will not condition my treatment on whether I sign this form; and (4) a photocopy or facsimile of this authorization shall be considered as valid as the original.

Signature of Patient/Legal Representative: _____

Date: _____

Printed Name & Relationship (if not patient): _____

Arizona Brain & Spine Center
Address: dryusupov@azbsc.com | Phone: 602-266-2272 | Fax: 602-266-2927