



ARIZONA STATE RADIOLOGY, PC

2492 E. River Road
Tucson, AZ 85718
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(520) 624-0117 (f)

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO ARIZONA STATE RADIOLOGY**

Patient's Legal Name: _____ M.R. #: _____
Address: _____ DOB: _____
City: _____ State: _____ Zip Code: _____
Primary Telephone No.: _____ Alternate Telephone No.: _____

Purpose of the Requested Use or Disclosure (check one): _____ Continuing Medical Care; _____ At My Request; _____
Filing Insurance Appeal; _____ Other: _____

Releasing Facility/Practice: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Fax No.: _____ Contact Person: _____

I hereby authorize the Releasing Facility/Practice identified above to release and disclose *to* Arizona State Radiology (ASR), a copy or an original of the following protected health information, including any confidential HIV/AIDS-related information, confidential communicable disease-related information, and/or information relating to any mental health and/or alcohol/drug use:

- | | |
|-------------------------|------------------------------------|
| _____ Orders | _____ Images |
| _____ Radiology Reports | _____ Films |
| _____ Correspondence | _____ Other (please specify below) |
| _____ Entire Record | |

(Other) _____

I understand that I may revoke this authorization at any time by notifying the Releasing Facility/Practice in writing, except to the extent that action based on this authorization has already been taken. Unless revoked, this authorization will expire on _____. If no date is provided it shall automatically expire six (6) months from the date on which it is signed. I agree to allow ASR to send the information to be released by fax or electronically.

Notice: The Releasing Facility/Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by ASR and may no longer be protected by federal privacy laws.

Signature of Patient/Personal Representative

Date

*If you are a Personal Representative, you must provide a description of your authority to act for the patient.

INTERNAL USE ONLY

Date records received by ASR _____