## RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Deticula Name						
Patient's Name:	First	Mi	ddle			
Home Address:						
nome Address.						
Home Telephone:	Date	of Birth:				
SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes						
☐ Discharge Summary	☐ Progress/Physician N	lotes 🗆	X-Ray Report	☐ Pathology Report		
☐ History & Physical	☐ Nurses Notes		EKG/EMG/EEG Repo	rt 🗖 Consult Report		
☐ Emergency Report	☐ Laboratory Report		Operative Report	☐ Entire Record		
☐ Other				-		
Records for the period (dates) from	to	)				
MY HIGHLY CONFIDENTIAL INFORMATION:						
use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:  Information about mental health or mental retardation services  Psychotherapy Notes created by a mental health professional  Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)  Information about sexually transmitted diseases  Information about alcohol or drug abuse treatment program services  Information about child abuse and neglect						
☐ RELEASE Information To:	□ RE	QUEST Inform	nation From:			
Name:			_			
Address:						
City:	State:		Zip Code:			
Telephone: ()	Fax:	()				
TERM: This Authorization will rema	ain in effect:					
☐ From the date of this Authorization	on until the	day of	, 20			
☐ Until Abrazo Medical Group fulfil	ls this request.					
☐ Until the following event occurs:						
☐ Other:						
PURPOSE: I authorize Abrazo Medical Group to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]						

## RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Abrazo Medical Group discloses my health information to the recipient, Abrazo Medical Group cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Abrazo Medical Group may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Abrazo Medical Group; except, however, if my treatment at Abrazo Medical Group is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Abrazo Medical Group may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Abrazo Medical Group's Privacy Office at the address listed below. The revocation will be effective immediately upon Abrazo Medical Group's receipt of my written notice, except that the revocation will not have any effect on any action taken by Abrazo Medical Group in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact Abrazo Medical Gi	roup's Privacy Office by mail at:			
	or by e-mail at HHH-Privacy@Te	netHealth.com.		
I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Abrazo Medical Group to use or disclose my health information in the manner described above.				
Signature of Patient		Date		
Note: If Patient is a minor or is other	erwise unable to sign this Authoriza	ation, obtain the following signatures:		
Signature of Authorized Personal Representative	Relationship to Patient	Date		
	Abrazo Medical Gr	oup		

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