Arizona Associates for Reproductive Health

Ketan S. Patel, M.D., F.A.C.O.G.

SCOTTSDALE
8573 E. Princess Drive, #101
Scottsdale, AZ 85255

GILBERT
3885 S. Val Vista Dr., #105
Gilbert, AZ 85297

Central Scheduling Office: (480) 946-9900 | Central Scheduling Fax: (480) 946-9914

AUTHORIZATION FOR USE AND/OR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: _____
First Middle/Maiden Last

Address: _____
Street City State Zip

Phone #:_____ **Date of Birth:**_____

Information Released From:

Facility Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Information to be Released TO:

Facility Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Dates of services being requested: From _____ To _____

Check the specific information to be released
(used or disclosed):

- ☐ Office Notes
- ☐ Radiology Reports
- ☐ Laboratory I Pathology Reports

Purpose of Disclosure:

- ☐ Medical Review
- ☐ Legal Review
- ☐ Insurance
- ☐ Personal Use
- ☐ Other_____

The named entity is authorized to (select both if applicable):

- ☐ Use protected health information for treatment, payment and operations
- ☐ Disclose protected health information to entity named

I understand that l have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclose of the private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of this information to be used or disclosed.

Reason for Request: _____

Printed Name: _____

Signature: _____ Date: _____