Arizona Pain and Spine Institute, PLLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

As required by the Health Information Portability and Accountability Act of 1996 and Arizona law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information complied in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **Arizona Pain and Spine Institute, PLLC**
Address: **2045 S. Vineyard Road, Suite 131**
City: **Mesa** State: **Arizona** Zip code: **85210**
Phone: **480-986-7246** Fax: **480-986-7252**

The request and authorization applies to:

- Health care information relating to the following treatment, condition, or dates:
  _____
- All healthcare information:
  _____
- Other:
  _____

I understand and hereby also consent to the release of any and all alcohol and/or drug abuse information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same conditions outlined below. I understand that such information cannot be released without my specific consent.

I understand that I have the right to revoke this authorization; I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature: _____ Date: _____