Scottsdale Ear Nose and Throat

A Division of VALLEY ENT, PC
8752 E. VIA DE COMMERCIO SUITE 1
SCOTTSDALE, AZ 85258
PHONE (480) 684-1080 **FAX (480) 684-1081**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, _____, hereby voluntarily authorize the disclosure of information from my health records.
(Name of Patient)

Patient Name: _____ Patient's Date of Birth: _____

Patient's Address_____ City _____ State _____ Zip Code _____

Home Phone _____ Cell or Work Phone _____

Information Requested:

_____The complete medical records pertaining to my treatment and care *(Excludes Psychotherapy Note)
Psychotherapy Notes must be on a separate request form.

_____Specific test, labs, notes or date of service _____

Purpose of Release: _____,
(Patient's request, dispute, referral, other)

Records from:

DR._____

Phone:_____

FAX:_____

Records to:

DR._____

Phone:_____

FAX:_____

1. **I understand that this authorization will expire on (insert date) _____.**
2. **I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Valley ENT P.C. in writing.**
3. **I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).**
4. **I may inspect or copy any information used or disclosed under this agreement.**
5. **I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.**

_____ _____
Patient's Signature or Patient's Representative **Date**

_____ _____
Print Name of Patient Representative **Relationship to Patient**

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM