ARIZONA STATE RADIOLOGY, PC
2492 E. River Road
Tucson, AZ 85718
(520) 722-8994 (t)
(520) 624-0117 (f)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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: ____

I hereby authorize Arizona State Radiology (ASR) to release to the Recipient identified below, 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
_______Radiology Reports
_______Correspondence
_______Entire Record
_______Images
_______Films
_______Other (please specify below)

(Other)____

Recipient: ____
Address: ____
City: ____________________________________State: ____________________Zip Code: _________________
Fax No.: _____________________________________Contact Person: _____________________________________

I understand that I may revoke this authorization at any time by notifying ASR 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: ASR 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 the Recipient 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.

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INTERNAL USE ONLY

Note: ASR's receipt of payment for records is authorized by law in certain circumstances.

Date payment received______________Amount received__________________ Check Cash CC

Date records sent/picked up by patient_______________Sent By____