



SAGUARO SURGICAL, P.C.

Vascular and General Surgery

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ To (date) _____

Please check type of information to be released:

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Pathology report	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results/reports	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Operative report	<input type="checkbox"/> Emergency room record	<input type="checkbox"/> Itemized bill

Other (specify): _____

I authorize the individuals listed below to receive my medical information:

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B & C testing, and/or other sensitive information, I agree to its release.

Check one and initial	
<input type="checkbox"/> Yes	Initials
<input type="checkbox"/> No	

I understand that if my medical or billing record contains information in reference To HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check one and initial	
<input type="checkbox"/> Yes	Initials
<input type="checkbox"/> No	

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time, I can revoke this authorization by submitting a notice in writing to the Privacy Officer at Saguaro Surgical, P.C. 6422 E Speedway Blvd – Suite, 150 – Tucson, AZ 85710. This authorization is valid for a period of six months from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization. However, authorization to release my medical records will be denied if I do not sign this form as specified.

I authorize Saguaro Surgical, P.C. to release the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____ Verified By: _____

Identity of Requestor Verified via: Photo ID Matching Signature Other (specify): _____