North Scottsdale Women's Care, P.C
Obstetrics & Gynecology

7970 E Thompson Peak Pkwy Suite 103
Scottsdale, AZ 85255
(480) 656-4840 FAX (480) 656-3310

Authorization for Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone: (Day) _____
_____ (Home) _____
Social Security # _____ Physician's Name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically expected: _____
_____

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information

From: _____ To: _____

Phone_____Fax_____ Phone_____Fax _____

II. Our Policy

As mandated by law we have 30 days to comply to all on-site medical record requests, for off-site requests the law mandates 90 day compliance.
North Scottsdale Women's Care makes every attempt possible to expedite each release in a timely fashion.
Should you need records for an immediate purpose, please fill out the appropriate fields below.
If you are in need of same day or next day records a $15 charge will be applied.
We reserve the right to charge for multiple record requests.

Reason(s) for this authorization (check all that apply):

☐ at my request _____

☐ transfer of care to _____

☐ other (specify) _____
_____
_____

Please indicate below if you need this information released prior to our 30 day allowance.

☐ Please have my records ready by (date) _____

This authorization ends: ☐ on (date) _____ ☐ when the following event occurs_____

III. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)