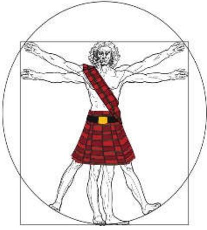

Scott Medical
SOLUTIONS
118 W. 5th St, Safford, AZ 85546
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AUTHORIZATION FOR RELEASE OF INFORMATION

In compliance with the Health Insurance Portability and Accountability act (HIPAA) of 1996 and 45 CFR 164 50B

I hereby voluntarily authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Patient Name:____ Date Of Birth:_________________

Address:____ City/State:____________________

Phone:____ SSN:________________________

Persons/Organizations Providing The Information:

____
____
____

Persons/Organizations Receiving The Information:

____
____
____

General Authorization: (Type and extent of information to be released)

☐ Complete medical records for all dates of treatment.

☐ Complete medical records for treatment dates from _________ to _________.

☐ Laboratory

☐ Progress Notes

☐ EKG

☐ X-Ray

☐ Pre-Employment Examination

☐ Specific Description of information (Including date(s)):_______________________________________.

This authorization shall be considered invalid 6 months or 60 days with respect to state and federal protected records from the date of signature.

I may revoke this authorization at any time by providing written notice of revocation. I may not, however, revoke the authorization retroactively for the information already released.

Patient (or Pt. Rep) Signature:_______________________________________ Date:_______________

Name/Relation of Patient Rep:____