

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

SS#: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

3. The type and amount of information to be used or disclosed is as follows:
My entire medical record, including but not limited to history and physical, progress notes, doctors orders, discharge summary, laboratory results, x-ray and imaging reports, consultation reports, any and all records or copies thereof, which you may have in your possession or under your control and all billings for all cost thereof.
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization
Bryon Middlebrook
BRYON MIDDLEBROOK, P.C.
308 North Agassiz Street
Flagstaff, Arizona 86001
(928) 774-1433
for the purpose of obtaining records for use in evaluating my claim and/or litigation currently pending.
6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: at the conclusion of claim and/or litigation. If I fail to specify an expiration date, event or condition, this authorization will expire in six month.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A copy of this authorization shall be accepted by you with the same authority as the original.

Signature of Patient or Legal Representative

Signature of Witness

Date _____

If signed by Legal Representative, Relationship to Patient