NORTH
SCOTTSDALE
FAMILY MEDICINE

6501 East Greenway Parkway • Building 6, Suite 160
Scottsdale, AZ 85254
480.948.9903 Office • 480.998.5887 Fax
www.nsfma.com

Release of Information Authorization

Patient Name: _____ **Birthdate:** _____

Approximate Dates of Service: _____

Purpose of Release: ☐ Continuing Health Care ☐ Legal ☐ Self ☐ Claim
☐ Insurance Needs ☐ Workman's Comp/Disability

I hereby Authorize _____ *Company/Person/Facility*

at this address _____ *Full Mailing Address*

_____

to release the information requested in the section below to be sent to:

This person or office _____ *Company/Person/Facility*

at this address _____ *Full Mailing Address*

_____

☐ *Initials*

I hereby consent to the release of records pertaining to treatment and/or diagnosis of the following:

- *Confidential Alcohol or Drug Abuse related information;*
- *Confidential HIV-related information;*
- *Confidential Mental Health Diagnosis and/or Treatment information;*
- *Confidential Communicable Diseases related information.*

☐ *Initials*

I understand that I may revoke this Authorization at any time, except to the extent allowed by law.
(Any use or disclosures made before the patient revoked the Authorization are not affected.)

☐ *Initials*

I also understand that information used or disclosed may be subject to redisclosure by the Recipient, and no longer protected by the privacy rule.

This Authorization Form will expire automatically ***one year*** from the date signed.

_____ _____

Signature of Patient or Patient's Authorized Representative *DATE*

_____ _____

Witness Full Signature
(Parent, Legal Guardian, Personal Representative, etc)

Relationship Status if Signed by anyone other than Patient