



**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

I authorize the following Physician: *All Information must be completed to process your request to disclose the following information from the health record of:*

Physician Name _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

PATIENT IDENTIFICATION <i>All information must be filled out completely to process your request</i>	Patient Name _____		Date of Birth _____
	Address _____ City _____ State _____ Zip _____		Phone Number _____
Dates of Service: From _____ To _____			
INFORMATION REQUESTED	<input type="checkbox"/> Office Visit Note(s) <input type="checkbox"/> Laboratory Results <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Report <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Billing Record	<input type="checkbox"/> Specify:
	PURPOSE <input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Attorney Request <input type="checkbox"/> Other (specify reason): _____		
INFORMATION TO BE SENT TO	_____ C. Daniel Murphy, MD _____ Therese Argyros, FNP _____ Jerome E. Rubbelke, MD		
	Dynamite Creek Medical Center 4712 E. Dynamite Blvd. Cave Creek, AZ 85331		Phone 480-342-8711 Fax: 480-342-7077

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Dynamite Creek Medical Center will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Dynamite Creek Medical Center Practice's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, **it will expire 6 months from the date signed** or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Dynamite Creek Medical Center, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient **or**
Description of Authority to Act for Patient

For Healthcare Use Only

Date Received: _____ **Date Sent:** _____ **Processor:** _____

