Neurology Consultants of Arizona

P: 480-977-6844
F: 480-977-6845
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Authorization for the Release of Medical Records

Patient Name: _____ DOB: _____

The above named patient is hereby authorizing the release of medical information:

☐ To: ☐ From: Neurology Consultants of Arizona
8415 N Pima Road, Suite 150
Scottsdale, Arizona 85258
Phone: 480-997-6844 Fax: 480-977-6845

☐ To: ☐ From: Facility or Doctor Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Reason: _____

The type of Information to be Disclosed is:

☐ Complete Medical Records x 2 years
☐ Progress Note(s)
☐ Lab Report(s)
☐ Pathology Report(s)/Operative Report(s)
☐ Ancillary Report(s) - Imaging
☐ Other: _____

Release and Waiver:

If the health information that I have requested Neurology Consultants of Arizona to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), Venereal disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Neurology Consultants of Arizona and their provider and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

This authorization shall be considered invalid after 1 year. I may revoke this authorization at any time by providing Neurology Consultants of Arizona written notice or revocation. However, I may not revoke the authorization retroactively for information already released excluding any/all information released prior to the revocation date. I hereby waive all provisions of law and privilege relation to the disclosure hereby authorized.

x _____ _____

Patient/Guardian Signature Date