TUCSON
Breast Health Specialists

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date: _____

Patent Name: _____

Date of Birth: _____ Phone Number: _____

This is: o A One-Time Disclosure o A Continuing Disclosure for 12 months from signed date

I hereby authorize _____ to release my medical records to:

Tucson Breast Health Specialists
5240 E. Knight Drive, Suite 114, Tucson, AZ 85712
Phone: 520-605-2778 Fax: 520-535-2232
info@tucsonbreasthealth.com

Please select one option below:

o Include all information regarding the examination, diagnosis and treatment rendered to me during the period from _____ to_____

o Include only the specific dates of service or diagnosis listed: _____

I hereby authorize the "Release of Medical Information / Protected Health Information." I, the patient, or patient's representative, have the legal right to inspect, copy and request delivery as specified in this Protected Health Information within the next 30 days in accordance with Public Law 104-191 (HIPPA-1996). I accept the responsibility of any fees that may be associated with this request. I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation.

Patient/Representative Signature: _____

Printed Name: _____ Date: _____

Please provide this Medical Records Request to the practice for which you are requesting records **from** and they will be sent to our office.