AUTHORIZATION FOR REQUEST OF RECORDS

Patient Information:

Name____Date of Birth______________________________

Address____

City/State/Zip____Phone____________________________________

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Facility RELEASING my health information:

Facility/Person____ ______________________________

Address____

City/State/Zip____Phone____________________________________

Facility/Person RECEIVING my health information: Fax______________________________________

Mind Body Spirit Center / Sherry Tackett
1702 E Bethany Home Rd Phone 602-277-1477
Phoenix, AZ 85016 Fax 602-277-4199

Description of information being disclosed for the following service or date(s) of service:

____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. I understand that my revocation won't have any effect on any action taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.
I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.
I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.
TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above: Yes No

Signature____Date_____________________

If signed by the patient's legal representative:____
Printed name of representative:____
Relationship to the patient:____

PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD

AUTHORIZATION FOR RECORD RELEASE

Patient Information:

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Address____

City/State/Zip____Phone______________________________________

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Facility/Person RELEASING my health information:

Mind Body Spirit Center / Sherry Tackett
1702 E Bethany Home Rd   Phone 602-277-1477
Phoenix, AZ 85016   Fax 602-277-4199

Facility RECEIVING my health information:

Facility/Person____ _______________________________

Address____

City/State/Zip_____________________________________Phone_____________________Fax_________________________

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I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.
TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above: Yes No

Signature____Date______________________

If signed by the patient's legal representative:____
Printed name of representative:____
Relationship to the patient:____

PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD