AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name First MI Last Date of Birth SSN

I authorize: Scottsdale Sinus and Allergy Center
Organization/Agency

7245 E Osborn Rd Suite 1 Scottsdale AZ 85054
Address City State Zip Code

to release information from my medical record to: ______________________
Organization/Agency

____
Address City State Zip Code

Purpose for disclosure: ______________________

The type of information to be disclosed includes:

- ☐ Progress Notes
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Ancillary Reports (Lab, X-ray, EKG, etc.)
- ☐ Verbal Communication
- ☐ Other ______________________

If applicable, the undersigned further authorizes Scottsdale Sinus and Allergy Center to disclose a copy of Record pertaining to:

1. Testing and/or treatment for AIDS and AIDS related diseases
2. Treatment for psychiatric illness
3. Treatment for drug/alcohol abuse

This authorization shall be considered invalid after 60 days. I may revoke this authorization at any time by providing Scottsdale Sinus and Allergy Center written notice of revocation. However, I may not revoke the authorization retroactively for information already released.

I hereby waive all provisions of law and privilege relating to the disclosure hereby authorized.

____
Signature of Patient or Legal Guardian Date

NOTE: In case a patient is physically unable to sign this authorization, he/she should place and "X" on the signature line and have his/her assent witnessed.

7245 E. Osborn Road, Suite 1, Scottsdale, AZ 85251 · 480-994-0308 · Fax 480-941-3740