DSS
Desert Surgical Specialists

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Authorization to Use or Disclose Protected Health Information
Patient Identifying Information

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To:
I hereby authorize _____to release my medical record information to:

Desert Surgical Specialists
19646 N. 27th Ave
Suite 201
Phoenix, Az 85027

Purpose of Request:❑ Personal❑ Continuing Care❑ Legal ❑ Other: _____

Specific Information to be Released:
Date(s) of Service: _____
❑ Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)
❑ Discharge Summary❑ History & Physical❑ Operative Report❑ ER Report❑ Consultation Report
❑ EKG❑ Diagnostic Imaging Reports❑ EEG❑ Lab Results❑ Pathology Reports❑ Diagnostic Films
(specify): _____❑Complete Records: Date of Visit _____
❑Other (specify): _____ ❑Family Practice Clinic (please request directly from the clinic)

I authorize the provider to use or disclose information related to: ❑AIDS/HIV and other Communicable Diseases ❑ Genetic Testing Information❑ Psychiatric Care Reports❑ Alcohol and/or Drug Abuse Treatment

I understand that Desert Surgical Specialists will not condition treatment on my signing this authorization. Desert Surgical Specialists will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions.
To revoke my authorization, I must submit a written request to Desert Surgical Specialists. Unless I *revoke* the authorization earlier, it will expire upon its completion or *60 days* from date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be *re-disclosed* by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

Signature of Patient_____Date:_____

Signature of Legal Representative:_____

Relationship to Patient or Description or Authority to Act for Patient _____