AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

WELCOME TO THE SUMMIT MEDICAL GROUP ARIZONA (SMGA)
HEALTH INFORMATION MANAGEMENT SERVICES DEPARTMENT

PLEASE READ THE FOLLOWING INSTRUCTIONS TO REQUEST A COPY OF YOUR MEDICAL RECORDS

HOURS: 8:00am – 5:00pm Monday through Friday

1. Please complete the "Authorization to Use and Disclose Health Information" form. Please mail or fax the completed form to the SMGA location of your provider:

Glendale: 5620 W. Thunderbird Rd, Ste F1, Glendale, AZ, 85306	**Fax: 602-938-6069**
Phoenix: 9150 W. Indian School Rd, Ste 118, Phoenix, AZ, 85037	**Fax: 602-938-6069**
Glendale: 18275 N. 59th Ave, Ste K162, Glendale, AZ, 85308	**Fax: 623-547-3443**
Avondale: 3400 N. Dysart Dr, Ste G127, Avondale, AZ, 85392	**Fax: 623-882-9977**
Sun City West: 14418 W. Meeker Blvd, Ste B110, Sun City West, AZ 85375	**Fax: 623-584-4945**
Goodyear: 14541 W. Indian School Rd, Ste, 600, Goodyear, AZ, 85395	**Fax: 623-535-4696**

2. **Please take note of the following:**

   A. We will complete your request within thirty days, at no charge to the patient.
      a. You will be provided with a CD/DVD containing electronic copies of your health information, mailed to the address indicated on your authorization form.
         - If you prefer to pick up your copies of medical records, you must indicate "Pick Up" on your authorization form. You will be called when your copies are ready for pick up.
           WHEN PICKING UP RECORDS, ONLY THE PATIENT OR AUTHORIZED REPRESENTATIVE MAY PICK UP THE RECORDS. PROOF OF ID IS REQUIRED.
           Also, please be aware that if you do not pick up records within 30 days, they will be discarded

   B. Initial record request for copies to be sent to a physician, who is not part of Summit Medical Group Arizona, will be copied at no charge. Records MUST be sent directly to your physician.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
First Last Middle Initial

Home Address: _____
Street Address

_____
City State Zip Code

Telephone: _____ Date of Birth: _____

PURPOSE OF DISCLOSURE:

☐ At the request of the patient (when the patient initiates the authorization)

☐ Other (please specify) _____

☐ I hereby authorize Summit Medical to disclose any and all of parts my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ('HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, (except for psychotherapy notes) chemical or alcohol dependency, laboratory test results, medical history, genetic testing, Sexually Transmitted Disease Testing, Diagnoses, & Treatment, or any other such related information.

RELATING TO THE TIME PERIOD _____ through _____
If nothing is selected, the COMPLETE file will be released.

If you would like your billing data to be released, please indicate here ☐

☐ I do NOT want the following information to be released: _____

RECIPIENT: To whom Summit Medical Group Arizona may disclose my health information:

Name: _____

Company: _____

Address: _____

Phone: _____ Fax: _____

OR

☐ **I WILL PICK UP RECORDS AT: American Medical Solutions:**
2222 W Parkside Ln, Ste 114,
Phoenix, AZ 85027

TERM: This authorization will expire upon SMG's release of my Health Information as needed to fully accomplish the purpose(s) listed below or 90 days from the date signed.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used and disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal and/or state confidentiality rules.

I hereby release SMGA and/or American Medical Solutions, Inc. from any liability which may result from this disclosure of medical information, or which may arise as a result of the use of information contained in the information released.

I understand that I have the right to revoke this Authorization, at any time before SMGA's reliance thereon, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in SMGA's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Summit Medical Group Arizona
5620 W Thunderbird Rd. Suite F-1
Glendale, AZ 85306
Attn: Adrianna Adams- Privacy Liaison

To check the status of your records request, please contact American Medical Solutions, Inc at 602-997-7041 specific office where records were request.

If you have any concerns, you may contact the HIMS Department at 602-564-6254 or the Privacy Liaison at 602-564-6274.

_____	_____
Signature of Patient	Date

If Patient is a minor or is otherwise unable to sign this Authorization, please obtain the following signatures:

_____	_____	_____
Signature of Personal Representative	Description of Personal Representative's Authority (i.e. POA, legal guardian- documentation required)	Date