



AUTHORIZATION FOR NOAH TO RECEIVE PROTECTED HEALTH INFORMATION FROM AN OUTSIDE ENTITY

1. PATIENT IDENTIFYING INFORMATION

Patient Name (First, Last): _____ Date of Birth: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date (s) of Service (s): _____

Name of Facility Sending the Records: _____

A. Release of records from Another Healthcare Provider to NOAH:

I authorize (Provider or Facility Name) _____ to release my medical records to NOAH as I have indicated in Section 2 below.

Phone Number of the Sending Facility: _____

Fax Number of the Sending Facility: _____

Note: Please mail or fax records to the NOAH facility indicated below.

Disclose to (Facility Name): Neighborhood Outreach Access to Health (NOAH)

Address: 3634 N. Drinkwater Blvd. Scottsdale, AZ 85251

Phone Number: 480-882-4545 Fax: 480-882-4594

2. SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED (CHECK ALL THAT APPLY):

Discharge Summary History and Physical Exam Operative Reports EKG
 X-Ray Reports Lab Tests Consultations Entire Record
 Pertinent Records Only Other (Specify) _____

A. Specific description of the purposes of the disclosure:

Continued Patient Care Workers' Compensation
 Insurance/Payment of Care The disclosure is at the patient's request

Other(Specify) _____

B. 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 NOAH will not condition treatment on my signing this authorization. NOAH 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. For more details on when I can and cannot revoke this authorization, I can read Scottsdale Healthcare's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to NOAH. Unless I revoke the authorization earlier, it will expire upon its completion or 90 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 member, and business associates information to the extent indicated and authorized herein.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____