Neighborhood Outreach Access to Health
7500 N. Dreamy Draw Dr., Ste 145
Phoenix, AZ 85020
Fax: (480) 882-4594

AUTHORIZATION TO SEND PROTECTED HEALTH INFORMATION FROM NOAH TO 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):_____

A. Release of medical records FROM NOAH:

I authorize NOAH to release my medical records as I have indicated in Section 2 below:

Disclose to (Patient Name or Provider Name):_____

Address:_____

Phone Number of Person or Office Receiving Records (Mandatory):_____

Fax of Person or Office Receiving Records (Mandatory):_____

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 sing 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 NOAH'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 regulation 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:_____