

FIT Health Care Clinic
4312 N 7th Avenue,
Phoenix, Arizona 85013
602.279.5049 Phone
602.279.5720 Fax
fithcc@gmail.com

Authorization to Release Medical Records/Health Information



1. I, _____ (print name) _____ (date of birth), hereby authorize the release of the below specified health information:

- All medical records **generated by this facility** (do not include records from other sources)
- All medical records **kept at this facility** (include copies of records from other sources)
- Records regarding these treatment dates and/or conditions:
 - Most recent exam chart notes, lab work and Pap results
 - Last ___ month(s) of my chart
 - Other: _____

2. I specifically authorize the release of information regarding the following condition(s), if any:

____ Drug Abuse ____ Psychological or Psychiatric Conditions ____ Substance Abuse ____ HIV/AIDS

3. For the following purpose(s):

- Continuing Medical Care Legal Insurance/Reimbursement Other _____

4. I authorize the following persons/agency to make these disclosures of health information:

Records Released **FROM**: _____ (Name)

_____ (phone #) _____ (Fax #)

By checking this box, I authorize this release / my records to be sent via fax.

5. I authorize the following persons/agency to receive these disclosures of my health information:

Records Released **TO**: **FIT Health Care Clinic**
 4312 N. 7th Avenue
 Phoenix, Arizona 85013
 Phone # (602) 279-5049 Fax # (602) 279-5720

A copy of this authorization shall be utilized with the same effectiveness as the original.

- I understand that I may revoke this authorization at any time as stated in Notice of Privacy Practices.
- I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on the authorization.
- I understand that this authorization will expire *one year from the date of this document*, or: _____ (Date of Expiration).
- I understand that charges may be incurred for copying costs. (The average rate is \$10.00 for the first 10 or fewer pages, 50 cents per page for pages 11-40, and then 25 cents per page after 40 pages).
- I understand that FIT Health Care may not condition treatment or payment on whether I sign this form.
- I understand that information that I have authorized be disclosed may be re-disclosed by the recipient and no longer will be protected by this authorization.

Patient Signature

Date