APNNA
Arizona Pediatric Neurology & Neurogenetics Associates, PLLC
3330 North 2nd Street, Suite 402
Phoenix, AZ 85012
Tel: 602-687-8555
FAX: 602-406-4067

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account No. _____

I AUTHORIZE _____
(Facility or Other Provider)

TO DISCLOSE TO: _____
(Persons/Organizations authorized to receive the information)

at the following address:

3330 North 2nd Street, Suite 402, Phoenix, AZ 85012

THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified below (check applicable boxes)

- ☐ Pertinent Information (H&P, discharge summary, consultation, operative
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Electrocardiograms
- ☐ Emergency Room
- ☐ Procedure Reports
- ☐ Progress Notes
- ☐ X-rays, CTs, MRIs (films or CDs)
- ☐ Laboratory Tests
- ☐ Pathology Reports
- ☐ EEGs
- ☐ Medications
- ☐ Billing Records

- ☐ Date(s): _____
- ☐ Other(s): _____
- ☐ **ALL RECORDS** regarding my treatment, hospitalization, outpatient care. A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

SENSITIVE INFORMATION: The information disclosed may include the following (initial applicable lines below):

_____ Genetic testing information
_____ HIV related information and other communicable diseases
_____ Drug/Alcohol related information

PURPOSE: The purpose of the requested use or disclosure is:

- ☐ At the request of the patient or personal representative
- ☐ Continued healthcare
- ☐ Insurance
- ☐ Legal Review
- ☐ Other: _____

LIMITATIONS: The following limitations apply to this authorization for disclosure:

- ☐ NONE
- ☐ OTHER: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different event or date is specified: _____
(insert date or event)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: APNNA – Arizona Pediatric Neurology & Neurogenetics Associates
  3330 North 2nd Street, Suite 402, Phoenix, AZ 85012

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Arizona law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE: _____ Date: _____
(Patient or Personal Representative)

Printed Name of Personal Representative: _____

Relationship to Patient: _____

Signature of APNNA representative: _____

Printed Name: _____ Date: _____