RINCON PAIN & SPINE

Patient Label

MEDICAL RECORD RELEASE

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. Requests are processed in the order in which they are received. It takes approximately 10-15 days to process your record request. Let us know if the requested information is needed by a specific date and every effort will be made to meet your needs. Federal and state laws govern release of medical information. Patients must provide photo identification in order to receive records.

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS: _____ PHONE: _____

CITY, STATE, ZIP: _____

RELEASE RECORDS: ☐ **TO** ☐ **FROM**

Rincon Pain and Spine
4747 E. Camp Lowell Dr.
Tucson, Arizona 85712
Fax: 877-319-3090
Phone: 520-731-5540

RELEASE RECORDS: ☐ **TO** ☐ **FROM**

Name/Organization: _____

Address:_____

City, State, Zip:_____

Fax:_____

Phone:_____

☐ Mail my records ☐ Call me when my records are ready for pick-up ☐ Fax my records to the above

TO BE RELEASED	**DATE OF SERVICE/ DATE RANGE**		**DATE OF SERVICE/ DATE RANGE**
☐ Procedure/Office notes	_____	☐ Radiology reports	_____
☐ Laboratory reports	_____	☐ Other:_____	_____

REASON FOR RELEASE OF INFORMATION

☐ Personal ☐ Legal Matter ☐ Insurance ☐ Other (DESCRIBE REASON FOR DISCLOSURE) _____

No records need to be sent. This release applies to verbal communication only with the following people:

1. _____ 2. _____ 3._____

I understand that the released records may contain records of medical conditions such as AIDS/HIV and other communicable diseases, behavioral health and psychiatric diagnoses, and/or alcohol and drug abuse, if any. Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in one year from the date of this signature.

_____ _____

Patient's or Authorized Personal Representative's Signature* **Date**

_____ _____

Relationship to Patient / Authority to Act on Patients Behalf **Interpreter, if Utilized**

STAFF ONLY	Date:	Verified by: **Signature validated against driver's license or signature in Medical Record**