

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **Parkway Medical/AccuCopy Service** to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name	Date of Birth	Social Security Number
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Description of information to be released:
_____ 2 years _____ 5 years _____ All _____ Billing _____ Other _____

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to: (check the appropriate category below)
_____ Hospital _____ Physician _____ Insurance Company _____ Attorney _____ Patient _____ Other

Name where records are being sent	Address	City	State	Zip
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I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
Expiration event/date

I further understand that I may revoke this authorization at any time by notifying Parkway Medical/Accu-Copy Service in writing at 6565 East Greenway Parkway, Suite 100, Scottsdale, AZ 85254. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

IT IS FURTHER UNDERSTOOD THAT THERE MAY BE A FEE FOR OBTAINING THESE RECORDS.

Signature of Patient or Patient's Representative **Date**

Printed Name of Patient's Representative **Relationship to Patient**

Legal Authority (attach supporting documentation)