Authorization to Release or Request Protected Health Information

PATIENT INFORMATION:		
Last Name:		**First Name:**
Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Date of Birth:**	

NAME OF PROVIDER OR HEALTHCARE FACILITY RELEASING INFORMATION:

Provider: Sun City West Medical Associates

Address: 14674 W Mountain View Blvd Suite 200		
City: Surprise	**State:** AZ	**Zip Code: 85374**
Phone Number: 623-544-6860	**Fax: 623-544-6861**	

From: / / **To:** / / ☒ All past and future Dates

Start Date **End Date**

NAME OF PROVIDER OR HEALTHCARE FACILITY REQUESTING INFORMATION [SEND TO]:

Provider: Physicians Health Center

Address:14674 W Mountain View Blvd Suite 100		
City: Surprise	**State: AZ**	**Zip Code: 85374**
Phone Number: 623-600-2406	**Fax: 623-900-7878**	

From: / / **To:** / / ☒ All past and future Dates

Start Date **End Date**

SIGNATURE REQUIRED:

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive my complete heath records electronically, in accordance with 21st Century Cures Act:

PHYSICIANS HEALTH CENTER

Name of Clinic

Note: Providers could incur significant penalties if OIG determines an organization or provider committed INFORMATION BLOCKING

Authorization to Release or Request Protected Health Information

My complete health records including:

☒ Mental Health ☒ HIV or AIDS ☒ Communicable diseases

☒ Treatment of alcohol/drug abuse

☒ Diagnosis, lab tests, prognosis, treatment, and billing for all condition

☒ Medical Treatment or consultation ☒ Billing or claims payment.

I understand the following:

<table>
<tr><td>♦ This authorization is valid for the information already in existence and any information that may be generated while this authorization is effective.</td><td>♦ The revocation will <u>not</u> apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.</td></tr>
<tr><td rowspan="2">♦ I have the right to see any information that is disclosed pursuant to this authorization for release, and I may request to see this information during normal business hours.</td><td>♦ Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization.</td></tr>
<tr><td>♦ I need not sign this form to assure treatment, payment or eligibility for services.</td></tr>
<tr><td>♦ I can revoke my authorization at any time and that the revocation will not apply to information that has already been released in response to this authorization.</td><td>♦ If the person or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential.</td></tr>
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I acknowledge that I have read this form, or it has been read to me and I understand its content.

Print Name: Date:

Signature: