DESERT SKY
SPINE & PAIN
FOCUSED ON FUNCTION

VOTED #1 PAIN MANAGEMENT CENTER 2020 WINNER

RELEASE OF INFORMATION

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 of which they are received. It can take approximately 7 to 10 business days to process and prepare your request. If the requested information is needed by a specific date, please let us know. Every effort will be made to meet your specific needs. Federal and state laws govern release of medical information. Patients must provide photo identification in order to receive records. Charges may occur.

Patient Name: _____ **Address:** _____

SSN: _____ **City/State/Zip:** _____

Date of Birth: _ _____ **Phone:** _____

Release Records ○ **To:** ○ **From:**

Desert Sky Spine & Pain
1521 E Tangerine Road Ste 201
Oro Valley, Arizona 85755
Phone: 520-229-2080
Fax: 520-229-2092

Release Records ○ **To:** ○ **From:**

Name/Organization: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

○ Mail my records when ready ○ Call me when my records are ready ○ Fax my records to the above

To Be Released:	**Date of Service/Date Range:**	**To Be Released:**	**Date of Service/Date Range:**
○ Procedure/Office Notes	_____	○ Radiology Reports	_____
○ Laboratory Reports	_____	○ Other: _____	_____

Reason for Release of Information:

○ Personal ○ Legal ○ Insurance ○ Other _____

Records do not need to be sent at this time. This release applies to verbal communication with the following:

1. _____ 2. _____ 3. _____

I understand that the released records may sensitive records of medical conditions, including but not limited to, AIDS/HIV and other communicative diseases, behavioral and psychiatric conditions, and/or alcohol and drug abuse. Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect this information. 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 expires one year from the date of this signature.

_____

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

_____

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

STAFF ONLY USE	**Verified By:**	**Date:**

Verify signature against driver's license