ARIZONA HIPPA MEDICAL RELEASE FORM

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize ____ to disclose the following information:

Name of clinic, individual, etc.

____ ______/ ______/ ________

Name (Please Print First/Last) Date of birth (MM/DD/YY)

____

Street Address City State Zip Code

( ) ___________________________ E-mail Address: _________________________________

Phone Number

I authorize the following person to receive my protected health information (PHI.

ARIZONA UROLOGICAL SURGEONS, LLC Office Of Dr. Hayyeri

Name of clinic, individual, etc.

1728 W. Glendale Ave., Ste. 204 Phoenix AZ 85021

Address City State Zip Code

(602) 775 – 5300 (602) 775 – 5301 WWW.ArizonaUrologicalSurgeons@gmail.com

Phone Number Fax Number E-mail

Information to be released (CHECK AS APPLICABLE)

Entire Record _____ Hospital _____ Labs _____ X-ray _____ Others _________________________

I understand information in my health record may include information relating to sexually transmitted disease, acquired immunodeficienvt syndrome (AIDS), human immunodeficiency virus (HIV), and other communicable daisies, genetic testing, developmental/behavioral health/psychiatric care, and treatment of alcohol and/or drug abuse. May signature authorizes such a release as indicated above.

I understand that the information disclosed by this authorization may be subjected to disclosure by the recipient and no longer protected by health insurance.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and the organization(s) listed above who I am authorizing to use and/or disclose may information may not condition treatment, payment, enrollment in the health care benefits and may decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I have read and understood the terms of this authorization and I have had a chance to ask questions about the use or discloser of my health information. I authorize the named above to use or disclose my health information in the manner described above.

Signature: ____ Date: _____________________________

Description of Authority to sign if personal/legal reprehensive;