

Authorization to Disclose Health Information

TUCSON ORTHOPAEDIC INSTITUTE



I, the undersigned, authorize:
Tucson Orthopaedic Institute
5301 E. Grant Road
Tucson, AZ 85712

Additional Locations:
6320 N. La Cholla, Ste 200, Tucson, AZ 85741
1521 E. Tangerine Rd., Ste 101, Oro valley, AZ 85755
395 N. Silverbell Rd., Ste. 101, Tucson, AZ 85745

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____
Patient Address: _____ Date of Birth: _____
City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

Patient's Identification Verified _____ -This box must be complete in order for request to be processed-
Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State _____ Zip: _____ Fax: _____
Purpose of Request: Personal Treatment Legal Insurance Disability
 Transfer/Reason _____ Other _____

Information to be Released

Section 1:

Charges For Patient Requesting:

* CD of Images: \$5.00

For doctor to doctor requests, there will be no fee. By default, the past two years of pertinent information will be sent. Please provide any specific additional information in Section 2: _____

Section 2:

Please provide information in my medical record for dates:

From _____ To _____

* Images on CD only

* Please Provide specific dates or Write ALL for ALL of your Images.

Form of Records

Please choose:

* Records on CD Only

* Choose One:

* Patient Pick Up Location:

* East/NW/St. Mary's/ Oro Valley

* Mail to Patient or Location (Release Information to Section)

Authorization to Release Protected

*Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one

Initial each line below

I DO DO NOT want information about *Mental Health released _____

I DO DO NOT want information about *HIV Tests & Related Information released _____

I DO DO NOT want information about *Alcohol and/or Substance Abuse released _____

I DO DO NOT want information about *Communicable Diseases released _____



Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature _____

Date: _____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 12 years and older for substance abuse records)

Signature of Parent or Legal Guardian _____

Date: _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.

I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.

I understand that my treatment or continued treatment by Tucson Orthopaedic Institute and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

I understand that I may inspect or copy the information that is used or disclosed.

Patient's Identification Verified - Initials of TOI Staff: _____