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Authorization for LifeScape Medical Associates, P.C. to Disclose Protected Health Information

Patient whose Protected Health Information is sought:

Patient _____
Last Name First Name Middle Initial Date of Birth MM / DD / YYYY
 Home Address _____
Street City State Zip Code
 Home Phone _____ Work Phone _____ Cell Phone _____

Person or entity to which Protected Health Information should be disclosed:

Name _____
Name of Person or Entity
 Address _____
Street City State Zip Code Phone Number

Description of Protected Health Information to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other _____
<small>Specify</small> |

Purpose(s) of the disclosure:

- | | |
|--|--|
| <input type="checkbox"/> Supplemental Care | <input type="checkbox"/> Insurance Coverage or Payment of Care |
| <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other _____
<small>Specify</small> |

I hereby release LifeScape Medical Associates, P.C. ("LifeScape") and its employees, officers, directors, shareholders, and agents from any and all liability for fulfilling this Authorization to Disclose Protected Health Information ("Authorization"). I understand that this Authorization may cover Protected Health Information ("Information") relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that any Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I may revoke this Authorization at any time, with some exceptions, provided I present written notice of such revocation to LifeScape. I understand that any disclosure made pursuant to this Authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that, for more details on when I can or cannot revoke this Authorization, I may read LifeScape's Notice of Privacy Practices a copy of which has been provided to me. I understand that this Authorization will expire upon the earlier of its revocation, LifeScape's completion of the disclosure, or ninety (90) following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this Authorization and that LifeScape will not condition or deny treatment because of my decision.

 Signature of the Patient or the Patient's Legal Representative

 Date

 Print Name

 If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient