



8757 East Bell Road
 Scottsdale, Arizona 85260
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Authorization to Disclose Protected Health Information to LifeScape Medical Associates, PC

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 from which Protected Health Information should be disclosed (“Provider”):

Name _____ Name of Person or Entity _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone Number _____

Entity to which Protected Health Information should be disclosed:

LifeScape Medical Associates, PC
 8757 East Bell Road
 Scottsdale Arizona 85260

Attn: _____

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 _____ Specify _____ |

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 _____ Specify _____ |

I hereby authorize Provider to release Protected Health Information (“Information”) to LifeScape Medical Associates, PC. I understand that this authorization may cover 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 I may revoke this authorization at any time by notifying Provider in writing. 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 this authorization will expire One Hundred Eighty (180) days 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 Provider 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