Thunderbird
INTERNAL MEDICINE

AUTHORIZATION FOR RELEASE OF RECORDS

I,_____ (Patient Name – Please print) Authorize Thunderbird Internal Medicine to release my medical records, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical and alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I authorize release of my protected health information to:

Facility/Requestor Name: _____

Address of above: _____

Phone and Fax of above: _____

Check appropriate requestor category: Medical facility__ Insurance__ Attorney__ Patient__ Other__

PLEASE CHOOSE ONE:

- ☐ This Authorization Is For Release Of Records Of My Care And Treatment For The Last ____ Years Inclusive.
- ☐ Specific Dates of Service _____

Disclosure of the information is requested for the purpose of:

_____

Patient's date of birth: _____ Social Security #: _____

Patient phone: _____ Expiration date of authorization: _____

_____ _____
Signature of PATIENT OR LEGAL REPRESENTATIVE Date

_____ _____ _____
Witness Signature Date Relationship to Patient

For the protection of the patient - This is not a valid release if not witnessed and if not entirely complete. This authorization is valid for 6 months unless revoked in writing. It cannot be revoked retroactively for information already released. Notice to patient: Thunderbird Internal Medicine utilizes a copy service to process medical records requests. Upon receipt of a HIPAA compliant release, requests may take up to 30 days to process depending on the type of request. Medical records will be sent to other doctors at no charge. If you wish a copy of your own medical records there is no charge for the first copy of your complete chart or any continuing updates. Should you require additional copies of your entire medical record in the future there will be a fee to be paid in advance by the patient. There will also be a fee for insurance companies and attorneys requests to be paid in advance by the insurance company or attorney. In the event the insurance company or attorney will not pay the fee, it will be the responsibility and at the discretion of the patient, to pay the fee. **All fees are based on size of chart and staff time to process the request. In addition, there will be a $35 fee to be paid in advance by the patient for any forms that need to be completed by any of our physicians. A $50 fee will be paid in advance by the patient for any stat forms that need to be completed within 72 hours by any of our physicians.**

If any portion of this authorization is returned incomplete, there will be a delay in the processing of this request until completion. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider, the release of information may no longer be protected by federal and state privacy regulations.

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