AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
ST JOSEPH'S OUTPATIENT SURGERY CENTER
ST. JOSEPH'S RECOVERY CARE CENTER

240 W. Thomas Rd. Phoenix,Az 85013
Phone: 602-406-6542 Fax: 602-926-8944

I hereby authorize **St. Joseph's Outpatient Surgery Center / St. Joseph's Recovery Care Center** to disclose all medical records, to include DRUG/ALCOHOL/PSYCHIATRIC records obtained in the course of the diagnosis and treatment of:

NAME: ____
DATE OF BIRTH: ____
DATE OF SERVICE: ____

RELEASE TO:

NAME: ____
ADDRESS: ____
CITY, STATE, ZIP: ____
TELEPHONE: ____
FAX: ____

For the purpose of: ____
____

Disclosure shall be limited to the following specific information:

- ❑ Operative Report
- ❑ History and Physical
- ❑ Labs
- ❑ Discharge Summary
- ❑ Billing Statement
- ❑ Other____

I may revoke this authorization at any time, in writing, except to the extent that the health care provider has taken action in reliance thereon. A copy of the authorization shall be considered as effective as the original. This authorization will remain in effect up to six months from the date of the patient's signature.

CONFIDENTIALITY NOTICE

The documents accompanying this transmission contain confidential health information that is legally privileged. This Information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately to arrange for the return or destruction of these documents.

____ ________________
Patient/Parent/Guardian/Authorized Representative **Date**