QUALITY OF LIFE
MEDICAL & RESEARCH CENTER

Quality of Life Medical Centers
5350 E. Erickson Drive
5390 E. Erickson Drive
Tucson, Arizona 85712
(520) 733-2250 phone
(520) 733-2270 fax

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

I HEREBY AUTHORIZE

☐ Quality of Life ☐ Facilities / Doctors Name: _____

Address: _____ City/State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

TO RELEASE

☐ **$25.00** for Complete Chart Record: *(If going to patient and to be paid at time of request).*

$0.00 if requested to be delivered to Physicians Office

☐ Chart Notes: ☐ ALL ☐ Specify: _____

☐ Labs/Reports: ☐ ALL ☐ Specify: _____

☐ Other: ☐ ALL ☐ Specify: _____

FROM THE HEALTH RECORDS OF

Patient Name: _____ D.O.B: _____

Social Security: _____ - _____ - _____ Daytime Phone: (_____) _____ - _____

Are you authorizing the release of your own medical records? ☐ YES ☐ NO

If not, what is the name and relationship to the patient?

Name: _____ Relationship: _____

TO BE RELEASED TO

☐ Quality of Life ☐ Self *(please indicate mailing address below)*

☐ Facilities / Doctors Name: _____

Address: _____ City/State: _____ Zip: _____

Phone No.: (_____) _____ - _____ Fax: (_____) _____ - _____

FOR THE PURPOSE OF:

☐ Concurrent Care ☐ Transfer of Care ☐ At My Request ☐ Other: _____

MY RIGHTS

I understand that unless revoked, this authorization is valid for 1 year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Also, I understand that I do not have to sign an authorization as a condition for receiving treatment or healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorized form to take part in a research study or to receive health care when the purpose is to create health care information for a 3rd party.

Unless specifically excluded, this authorization includes release of specially, protective information requiring my explicit authorization or release. This includes referrals, diagnosis and treatment information related to: (check the accompanying box(s) below to EXCLUDE the information authorization):

☐ Substance Abuse ☐ Mental Health Condition ☐ Sexually Transmitted Diseases ☐ HIV/AIDS ☐ Genetic Testing

I understand that once healthcare information is disclosed, the person or organization that receives it, may re-disclose it, and that it may no longer be protected by privacy law.

Patient Signature: _____ Date: _____