NORTH SCOTTSDALE
OUTPATIENT SURGERY CENTER

I, _____ , authorize North Scottsdale Outpatient Surgery Center to disclose the following patient's information:

Patient name: _____ DOB: _____ MR#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Information requested: _____
Dates of requested information: _____ to _____.
Purpose for requested information: □ Self □ Continuing Medical Care □ Attorney Request
□ Other, please specify: _____

Information to be sent to:
(Company, Person, Facility) _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

I understand that information in my health records may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that NSOSC will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. NSOSC's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, it will expire 6 months from the date signed.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release NSOSC, its employees, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Patient signature: _____ Date: _____

Signature of legal guardian: _____ Relation: _____

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