AUTHORIZATION TO REQUEST MEDICAL INFORMATION

Provider Approval
Initials: ________
Date: ________

UM* ____________________ Patient Number

____________________ Patient Name

I REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:

____

____

____

____

Phone (____)____________ Fax (____)____________

INFORMATION TO BE RELEASED TO:
United Medical Clinics
RECORDS DEPARTMENT
2821 N. 24th St. Phoenix, AZ 85008
(602) 955-1444 FAX (602) 467-3287

Name of UMMC Provider Needing Records (if known): ____________________

My initials and signature below authorize the release of health care information relating to testing, diagnosis, chart notes and treatment for all of the following:

Other: Specify Previous 12 Months Medical Records

____

____

For care provided on: - Present **(Provide the date or dates of treatment, if known)**

The above information will be used for the following purpose(s):

Diagnosis of intractable pain
Medical evaluation
Continued medical care with United MMC clinics

I expressly and voluntarily authorize disclosure of the above medical record(s) for the purpose(s) stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization. I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment, or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that once this health information has been disclosed, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

This authorization expires 30 days/Signature Date **(State date or event, required for release of records)**

X ____ Signature of patient   DATE ____________

Patient SSN ____________ DOB ____________ Other Names Used NA