



the mandel center

**The Mandel Center of Arizona**

*Alyssa Mandel, LCSW*

8120 East Cactus Road • Suite 310

Scottsdale, AZ 85260

Office: 480.734.1199

Fax: 480.551.3363

www.mandelcenter.com

## Authorization To Disclose Health Information, Page 1

Client Name: \_\_\_\_\_

Health Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ S.S. No.: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

*The Mandel Center of Arizona and Alyssa Mandel, LCSW*

*8120 East Cactus Road, Suite 310, Scottsdale, Arizona 85260*

*Tel: 480-734-1199*

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

\_\_\_ problem list

\_\_\_ medication list

\_\_\_ list of allergies

\_\_\_ immunization record

\_\_\_ most recent history and physical

\_\_\_ most recent discharge summary

\_\_\_ laboratory results / from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

\_\_\_ x-ray and imaging reports from / from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

\_\_\_ consultation reports from / (doctor's names) \_\_\_\_\_

\_\_\_ entire record

\_\_\_ other \_\_\_\_\_

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

*For the purpose of: (insert reason i.e. personal injury claims/settlement).*

\_\_\_\_\_



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## Authorization To Disclose Health Information, Page 2

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

\_\_\_\_\_

8. California/Arizona Restriction. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. You are further authorized to discuss my case in detail with \_\_\_\_\_ or their representatives, and assist them in any way they may request your services.

10. I acknowledge receipt of a signed copy of this authorization \_\_\_\_\_ (Initials)

11. This Authorization is good for one year at date of signing or until \_\_\_\_\_.

*Signature of Client or Legal Representative:*

*Date:*

\_\_\_\_\_

\_\_\_\_\_

If Signed by Legal Representative, Signature of Witness:

Relationship to Client:

\_\_\_\_\_

\_\_\_\_\_

*A photocopy of this Authorization will be considered as an original. This Release complies with the HIPAA Privacy Rules.*

*Where journeys begin*