Cochise Health and Wellness, PLC

4677 North Commerce Drive • Sierra Vista, AZ 85635 • Phone: 520.226.8316
•Fax: 520-459-8567 (HIPAA-Compliant)

AUTHORIZATION FOR RELEASE OF *or* AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Note: All information must be provided – incomplete forms can not be processed

PATIENT NAME: ________________________ DATE OF BIRTH: ______________

Address: ________________________ Phone: ______________

City, State, Zip Code: ________________________

PURPOSE OF RELEASE (please specify):

Continuity of Care Personal Use Other: ________________________

RECORDS TO BE RELEASED FROM:

Name: ________________________

Address: ________________________

City, State. Zip Code: ________________________

Phone: ______________

Please send records to (fax preferred):

Cochise Health and Wellness, PLC

4677 North Commerce Drive

Sierra Vista, AZ 85635

Fax: 520-459-8567

Information to be released: (circle any that apply)

MENTAL / BEHAVIORAL HEALTH VISITS ALL CONSULTATIONS & OFFICE VISITS (3 years maximum)

RADIOLOGY Reports CD w/ image LABORATORY HOSPITAL CONSULTS & PROCEDURES

OTHER: ________________________

Dates of records to be included: FROM: ______________ TO: ______________ OR ☐ PRESENT
NOT TO EXCEED 3 YEARS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment) except to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I understand that the released records may contain references to medical conditions such as AIDS/HIV and other Communicable Diseases, Behavioral Health and Psychiatric Diagnoses, and/or Alcohol and Drug Abuse, if any.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest the claim. To revoke this authorization write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it. I understand that if this office requested this authorization I have the right to receive a copy of it.

I understand records will be sent by HIPAA fax or mail within 30 business days of receipt of this request.

I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THIS SIGNATURE.

PATIENT SIGNATURE: ________________________ DATE: ______________

LEGALLY AUTHORIZED REPRESENTATIVE: ________________________ DATE: ______________

OFFICE USE ONLY

Identity verified by: ________________________

Request submitted:

Fax ________
Mail ________
Other ________

Revised: 20 Jan 16