AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Faxed or Mailed Requests MUST be accompanied with a copy of a government issued ID, for verification purposes. Please send all requests to:

The CORE Institute®
Medical Records Department
3010 W. Agua Fria Freeway, Suite 100
Phoenix, AZ 85027
T: 866.974.2673 F: 623.474.3401

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: (____) ____-_____ CORE Patient ID#: _____ CORE Provider: _____

I hereby authorize The CORE Institute to disclose the following Protected Health Information pertaining to the above referenced patient to or to be requested from:

Name of Person or Entity: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

For the Purpose of: ___ Self ___ Continuing Care ___ Other: _____

Information Requested:
___ All Records
___ Operative Report from ____ / ____ / ____
___ Progress Note from ____ / ____ / ____
___ Radiology report from ____ / ____ / ____
___ Radiology CD from ____ / ____ / ____
___ Other: _____

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist. I understand that The CORE Institute will not condition my treatment on whether I sign this Authorization. I understand that I have the right to revoke this authorization at any time except to the extent that The CORE Institute has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: The CORE Institute, Attention: Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the information. I understand that failure to accurately complete this form may delay or prevent processing. I understand that personal requests are subject to labor and materials recovery charges.

This authorization will expire six (6) months from the date of signing unless otherwise specified: ____/____/____

_____ _____ _____
Patient Signature or Legal Representative | Date | Relationship to Patient

_____ _____
ID verified & accepted by: (CORE Staff) | Date

FOR MEDICAL RECORDS USE ONLY

Date Completed: _____
MRS Completed: _____
Records were: MAILED / FAXED / OTHER: