ADOBE
ENT & ALLERGY

Surgeon:
Dr. Michael Rodriguez , DO

20325 N 51st Avenue
Ste 154
Glendale, AZ 85308
P: 623-900-4740
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ADOBE ENT & ALLERGY HIPAA MEDICAL RELEASE FORM
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize_____ to disclose the following information from the health records of:
(Name of clinic, individual, etc)

_____ _____
Patient Name (Please print first/last name) (If Applicable) Legal Guardian's Name

_____/_____/_____ (_____)_____
Patient's Date Of Birth (MM/DD/YY) Phone Number

_____
Street Address

_____ _____
City/State/Zip Code Email Address

I authorize the following person (or class of persons) to receive my Protected Health Information (PHI):

_____ (_____)_____
Name (Please Print) Phone Number

_____
Street Address

_____ _____
City/State/Zip Code Email Address

Information to be Released (check as applicable):

☐ Allergy Records	☐ Sleep Records	☐ Audiology Records	☐ Aesthetic Records	☐ Consultations	☐ Developmental/ Behavioral
☐ Discharge Summary	☐ Drug/Alcohol Treatment	☐ Genetic Testing	☐ HIV/AIDS	☐ History & Physical	☐ Hospital Records & Reports
☐ Immunizations	☐ Surgical Reports	☐ Laboratory Reports	☐ Prescriptions	☐ Psychiatric	☐ Sexual Assault
☐ Sexually Transmitted Disease	☐ Treatment or Tests	☐ X-ray/Imaging Reports	☐ Other communicable diseases	☐ Other (Specify):	

— OR —

☐ ENTIRE RECORD, excluding the following (check applicable):

☐ Sexually Transmitted Disease	☐ HIV/AIDS	☐ Other communicable diseases	☐ Genetic Testing	☐ Psychiatric	☐ Developmental/ Behavioral
☐ Information about child abuse/neglect	☐ Drug/Alcohol Treatment				

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For the following date(s) of service

From (MM/DD/YYYY) _____/_____/_____ To (MM/D/YYYY) _____/_____/_____
Will automatically expire in sixty (60) days

Purpose of Disclosure (Check Applicable Categories):

☐ Treatment	☐ Research	☐ Medical Hardship Waivers	☐ Legal Investigation or Action	☐ Insurance Eligibility/ Benefits	☐ Other (Specify)

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand hat I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization.

I may revoke this authorization at any time providing I notify in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentially. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

I have read and understood the terms of this Authorization and I have had a chance ask questions about the use or disclosure of my health information. I authorize the named entity above (page1) to use or disclose my health information in the manner described above.

SIGNATURE: _____ Date: _____

Description of Authority to Sign If Personal/Legal Representative:

_____

IDENTITY OF REQUESTOR VERIFIED VIA:

☐ Photo ID	☐ Signature	☐ Other: _____