THE AFA BALANCE & HEARING INSTITUTE
A.T. STILL UNIVERSITY OF HEALTH SCIENCES

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AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____-_____-_____ _____
Patient Name Social Security Number Date of Birth

I authorize AFA Balance & Hearing Institute to: ☐ Release information to: **OR** ☐ Obtain information from:

_____ (___)_____-_____ (___)_____-_____
Physician/Organization Phone Fax

_____
Address City State Zip

Release the following information from my medical records:

☐ Complete Record ☐ All Test Results ☐ Other (Please Specify) _____

The purpose for this request is for: (check all that apply)

☐ Further Medical Care ☐ Payment of Insurance Claim ☐ Other_____

☐ **I DO** ☐ **I DO NOT** authorize the facsimile (FAX) transmission of the above records

NOTICE: This information has been disclosed to you from records protected by Federal and State confidentiality rules (42CFR Part 2 and /or ARS 36-3661). The rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by statue. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

X _____
Signature of Patient Date

X _____
Signature of Authorized Person Relationship to Patient

X _____
Signature of Witness Information Released By Date