Steingard
STEINGARD MEDICAL GROUP, P.C.

Scott A. Steingard, D.O.
Family Practice
Board Certified, A.O.B.F.P.
Sports Medicine-Manipulative Medicine
Sports Medicine-C.A.O., A.O.A.S.M.

Jason H. Turner, M.D.
Family Practice
Board Certified, A.B.F.P.

Milissa A. Cooper, D.O.
Family Practice
Board Certified, A.O.B.F.P

Tiffany M. Tapia, MMS, PA-C
Board Certified

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I herby authorize **STEINGARD MEDICAL GROUP/AMS** to **DISCLOSE** my individual identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Print Patient Name **Date of Birth** **Social Security**

Date(s) of Service (if known) _____

Reason or purpose of the use and/or disclosure: _____

The health information described herein shall be released to:
Hospital ____, Physician ____, Insurance Co. ____, Attorney ____, Patient ____, Other _____

Description of information to be released:
2 years _____, 5 years _____, All _____, Billing _____, Time Frame from _____ to _____

Disclosing Information To (Name) **Address** **City** **State** **Zip**

Phone: _____ **Fax:** _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify by date or by event. I desire this authorization to be in effect until _____

I further understand that I may revoke this authorization at any time by notifying **Steingard Medical Group** in writing at **5830 N. 19th Ave, Phoenix, AZ 85015. PHONE: 602-336-1966, FAX: 602-336-0044.** I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provided, the released information may no longer be protected by federal and state privacy regulations.

_____ _____
Signature of Patient or Patient's Representative **Date**

_____ _____
Printed Name of Patient's Representative **Relationship to Patient**

Charges are as follows: Patients: Paper copies 50 cents per page for pages 1-25, $25 for pages 26-100, $50 for 100 or more pages. $25 for records on a CD. There is no charge for provider to provider care. We accept cash, checks and credit cards. If picking up records, please bring a photo ID.

Employee accepting request: _____ **ID Checked** ____**Yes** ____**No Amt. of payment received:** _____

Request Completed: ____**No** ____**Yes By Whom:** _____ **Date:** _____