Authorization to Disclose Health Information
Fax: 866.939.2673

I, the undersigned, authorize The CORE Institute to disclose the information described below to the recipient(s) described below. I understand and agree to the statements and information contained in this authorization.

PATIENT INFORMATION

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____

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

Other Names During Treatment: _____

RELEASE INFORMATION

Please complete this section and check mark next to the appropriate to/from box in order for the request to be processed:

☐ **Release Information to** **OR** ☐ **Request Information from**

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax Number: _____

Purpose of Request: ☐Personal ☐Treatment ☐Legal ☐Insurance ☐Disability ☐Military/VA

Transfer/Reason: _____ Other: _____

Fees

- **For Personal Requests,** there will be a **$15.00 handling fee per request for paper or CD, plus an additional fee of $0.29 per page after the first five pages.**
- **For Requests sent to another healthcare provider**, there will be no fee.

INFORMATION TO BE RELEASED

Please provide information in my medical records for dates: From: _____ To: _____

By default, the past two (2) years of pertinent information will be sent.

Place a check mark next to the requested records:

☐ Chart Summary	☐ Office Visit Notes	☐ Images on CD	☐Physical Therapy Notes
☐ Laboratory Tests	☐ Imaging Reports	☐ Entire Medical Record	☐ Entire Medical Record, including outside documents
☐ Genetic Testing/Studies	☐ Phone Notes	☐ Other: _____	

FORM OF RECORDS

Please choose: ☐Records on Paper ☐Radiology images on CD

☐Records via eDelivery, requires email address: _____

AUTHORIZATION TO RELEASE PROTECTED

Required – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check One			Initial Each Line Below
I	☐ Do	☐ Do Not	want information on **Mental Health** to be released	_____
I	☐ Do	☐ Do Not	want information on **HIV Tests and Related** information to be released	_____
I	☐ Do	☐ Do Not	want information about **Alcohol and/or Substance Abuse** released	_____
I	☐ Do	☐ Do Not	want information about **Communicable Diseases** released	_____

Please confirm that you have put a **checkmark and initialed** all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

- This authorization will expire 90-days from the date appearing above. I understand that I may revoke this authorization at any time by notifying The CORE Institute in writing to: ***The CORE Institute, 18444 N. 25th Ave, Suite 320, Phoenix, AZ, 85023 or via fax to 866.939.2673***. If I do, it will not have any effect on the actions The CORE Institute took before it received the revocation.
- I understand that under the applicable law the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- The CORE Institute may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that I may inspect or copy the information that is used or disclosed.

Patient Signature: _____ Date: _____

If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the individual, e.g., "parent" or "guardian ad litem"

Signature of Parent or Legal Guardian: _____ Date: _____