Laurie Thomas MD
1601 N Tucson Blvd #2
Tucson, AZ 85716
(520) 400-8223
lauriethomasmd.com

Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Name _____ Today's Date _____
Patient's DOB _____

By signing, I authorize _____
_____
_____

to disclose certain protected health information (PHI) about me to

Laurie Thomas MD
1601 N Tucson Blvd #2 PLEASE SEND RECORDS BY MAIL
Tucson, AZ 85716

This authorization permits _____to disclose the following individually identifiable health information about me:
Progress notes - last 2 years
Test results - last 2 years
Problem list, Medications, Allergies, Immunizations, QIS (Health Care Maintenance)

The information will be used or disclosed at my request. I do not have to sign this authorization in order to receive treatment from **Laurie Thomas MD**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. This authorization will expire on _____.

Signed: _____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Relationship to Patient

Patient/guardian must be provided with a signed copy of this authorization form.