City of Mesa Health and Wellness Center
1121 S. Gilbert Rd.
Mesa, AZ 85204
Phone 480-644-well
Fax 480-644-2288

PATIENT AUTHORIZATION OF PROTECTED HEALTH INFORMATION

Patient Name _____ Medical Record # _____
Date of Birth _____ SS# _____ Phone # _____
Patient Address _____

1. I authorize the following health care provider or facility to DISCLOSE my patient information:
   _____ Outpatient Clinic(s): _____
   _____ Specific Provider(s): _____
   _____ Other: Name/credentials: _____
   Address:_____
   Phone #: _____ Relationship to patient: _____
2. Please disclose the following information: (circle all that apply)
   History and Physical Psychological Evaluation Discharge Summary Educational Report
   Treatment Plans Psychosocial History Consultation Reports Immunizations
   Operative/Procedure Notes Outpatient Clinical Records Radiology and Lab Reports
   Other: _____
3. Please indicate the purpose of the disclosure of your patient records: _____
   Check here if it is for your own personal use: _____
4. If applicable, I understand that based on the dates, providers, and information I have designated above, the disclosure the healthcare provider makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.
5. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal regulations, the information they receive will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
6. I understand that the healthcare provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: OnSite Care, 215 S State SLC, UT 84111.
8. I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one):
   ____ 1 year from date below _____ One time disclosure only _____ Other: _____

_____	_____
Signature of patient or patient representative	Date
_____	_____
Name of patient representative	Relationship to patient

Signature must be verified by OnSite Care staff or must be notarized

_____	_____	_____
Staff signature	Printed staff name	Date