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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO: _____
NAME OF HEALTHCARE PROVIDER/PHYSICIAN/FACILITY/ATTORNEY/RECORDS REQUESTOR/AGENT, ETC.

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

RE: PATIENT NAME: _____

DATE OF BIRTH _____ SOC SEC NO: _____

This protected health information is disclosed for the purposes: _____

I authorize and request the disclosure of all protected information for the purpose of: _____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

() All medical records, meaning every page in my record, including but not limited to: office notes, face sheet, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical chart, reports, order sheets, progress notes, nursing notes, clinic records, treatment plans, admission records, discharge summaries, procedure reports, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

() All medical billing records including all statements, insurance claim forms, itemized bills, and records of billing third payers and payment or denial of benefits for the period of _____ to _____.

() All physical, occupational and rehab records, consultations, and progress notes.

() All laboratory, histology, cytology, pathology, autopsy, immunohistochemistry records and specimens; radiology reports and films/CDs if kept in office, CT scan, MRI, MRA, EMG, bone scan, myelogram, nerve conduction studies.

() All pharmacy / prescription records as documented in clinical electronic medical records.

