AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient: _____ _____
(Include previous names) Date of birth

AUTHORIZES RELEASE OF PROTECTED HEALTH INFORMATION

FROM: _____
Name of physician or health care facility

Address: _____

_____

_____ _____
Phone Fax

TO: **Moon Valley Health**
14045 N 7th St Suite 3
Phoenix, AZ 85022
602-795-5505
602-795-9277 FAX

I understand that IF the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your rights with respect to this authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting *Moon Valley Health*
Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to Withdraw This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Moon Valley Health. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.
Expiration Date: This authorization is good for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature (Patient or Legal Representative)**:** _____
(If signed by other than patient, state relationship and authority to do so.)

Date: _____

Witness: _____