Authorization to Use or Disclose Health Information

To: _____ Phone: _____ Fax: _____

YOU ARE HEREBY AUTHORIZED TO FURNISH RECORDS TO:

American Injury Network, Inc. ☐ STAT
7904 E Chaparral Rd, Ste. A110-508
Scottsdale, AZ 85251
P: 480-688-1894 F: 480-907-1277 Email: frontdesk@americaninjurynetwork.com

PRINT NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SSN: _____

DATE OF ADMISSION or VISIT: _____

I authorize the use or disclosure of the above-named individual's health information as described below. The following individual(s) or organization(s) are authorized to make the disclosure. The type of information to be used or disclosed is as follows:

☐ X-RAY/IMAGING REPORTS: _____

☐ LAB RESULTS: _____

☐ MOST RECENT HISTORY

☐ CONSULTATION REPORTS

☐ ENTIRE RECORD

☐ OTHER: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. The information identified above may be used or disclosed to the facility named above. I understand that I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and present any request to *American Injury Network, Inc. (AIN)*. I understand this revocation will not apply to information previously released. This authorization will expire within seven (7) years of the original date. I understand that medical information received to *American Injury Network, Inc. (AIN)* may be re-disclosed and may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure consent of my health care treatment records.

Signature of Patient: _____ Date: ___ /____ /_____