ARIZONA CENTER FOR
Hand to Shoulder Surgery

Hand to Shoulder Surgery & Reconstructive Microsurgery • www.achssurgeons.com
Phone (602) 258-4788 • Fax (602) 258-5131

HIPAA DISABILITY CONSENT FORM

Under the **HIPAA Privacy Rule** and as outlined in our Notice of Privacy Practices, we do have the right to disclose medical information to certain individuals to aid in your continuity of care. By signing below you acknowledge that if the recipient is not a healthcare provider, a health plan or healthcare clearing house or not an entity required to comply with federal or state health privacy regulations, this information may be further disclosed by the recipient and may no longer be protected by state and federal law. By signing you also understand that the release of your medical records may include information pertaining to psychiatric issues, HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, genetic issues, behavior or mental health services.

Patient's Name: _____ **Date of Birth:** _____ **Account #:** _____

Please indicate how/where you would like your forms sent by completing the following fields.
All spaces must be filled in. If non-applicable, write N/A.

ACHS will only speak to or release information to the Entity/Company named below regarding your disability or any other claim

Name of person receiving information: _____ **Company:** _____

Address: _____

Phone: _____ **FAX:** _____

FORM DEADLINE: _____

Reason for Disclosure: _____

_____

Name of person receiving information: _____ **Company:** _____

Address: _____

Phone: _____ **FAX:** _____

FORM DEADLINE: _____

Reason for Disclosure: _____

_____

Please initial here to indicate that the patient wishes to call in with fax number_____

By signing below I give the above Companies/Employers consent to receive my medical information. I acknowledge that this form **expires 1 year from the date of signature below.** If at any time prior to this date I wish to change/revoke the consent for the individual(s)/company's or employer's listed below, I am aware that I **must** notify the office in writing (i.e., complete a new form). If I need my medical information released after 1 year from the date of signature below I will need to complete an updated form.

I understand that there is an initial **$35.00 charge** for the first form filled out by your office and that an additional **$20.00 charge** will be incurred for *any/all subsequent forms/updates*. I understand that the form cannot be completed and released until payment has been made and there is a signed consent on file. Once the applicable payment has been received, our Office Policy states it can take up to **5 – 7 business days** for the form(s) to be completed.

Signature: _____ **Date of Signature:** _____

PAID **NOT PAID** **Notes:** _____

Additional Notes: _____

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