LifeScape
PREMIER

Authorization to Disclose Protected Health Information to LifeScape Premier, L.L.C.

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Patient whose Protected Health Information is sought:

Patient _____ Last Name _____ First Name _____ Middle Initial _____ Date of Birth _MM_ / _DD_ / _YYYY_

Home Address _____ Street _____ City _____ State _____ Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

I hereby authorize LifeScape Premier/LifeScape Medical Associates to request my medical records from:

Name _____ Name of Doctor, Medical Office or Entity _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone/Fax Number

Protected Health Information should be disclosed to:

LifeScape Premier, L.L.C.
8757 East Bell Road
Scottsdale Arizona 85260
Tel. 480.860.5269
Fax. 480.860.5260

Attn: _____

Description of Protected Health Information to be disclosed:

- ☐ Complete Medical Record
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ X-Ray Reports
- ☐ Lab Tests
- ☐ Other _____ Specify

Purpose(s) of the disclosure:

- ☐ Supplemental Care
- ☐ Second Opinion
- ☐ Transfer of Care
- ☐ Personal Use
- ☐ Insurance Coverage or Payment of Care
- ☐ Workers' Compensation
- ☐ Legal
- ☐ Other _____ Specify

I hereby authorize Provider to release Protected Health Information ("Information") to LifeScape Premier, L.L.C. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____   _____
Signature of the Patient or the Patient's Legal Representative   Date

_____   _____
Print Name   If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.