Dina Health Services, PLLC

Provider Name:_____ Telephone:_____ Fax:_____

Patient Name:_____SSN: X X X - X X - __ __ __ __ DOB: __ __ / __ __ / __ __ __ __

AUTHORIZATION FOR RELEASE. I hereby authorize and direct the record custodian or other agent of the above referenced facility to release, disclose and deliver certified information to:

Dina Health Services, PLLC
7140 E. 1st ave,
Scottsdale, AZ 85251
T (480) 331- 6271
F (480) 425-2227

SPECIFIC AUTHORIZATION. I specifically authorize the release of medical information relating to the above-named patient and of only the following **Qualifying Medical Condition:**

Cancer ☐	Glaucoma ☐	HIV ☐
AIDS ☐	Hepatitis C ☐	ALS ☐
Crohn's disease ☐	Epilepsy ☐	Alzheimer's Agitation ☐
Multiple Sclerosis ☐	Cachexia ☐	Severe and chronic pain ☐
Severe nausea ☐	Severe muscle spasms ☐	

This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider or another entity. I understand and acknowledge that the release of records may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis.

REDISCLOSURE. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

VALIDITY. I understand that this authorization will automatically **eighteen months** from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall no constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above. I understand that a reasonable fee may be incurred to copy and release the medical information.

_____ _____

Patient or legally authorized individual signature **Date**