AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Applicant Name: _____ Date: _____

Patient Name (if different :) _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: H) (_____) _____ W) (_____) _____

Facility Name: _____ Facility Phone: (_____) _____

Facility Address: _____ Facility Fax: (_____) _____

City/State/Zip: _____

This information may be disclosed to and used by the following organization:

Lupus Foundation of Southern Arizona

Address: 4602 E Grant Road, Tucson, AZ 85712
Fax: (520)798-0972 - Phone: (520)622-9006

Health information to be released: Confirmation of SLE (Lupus) diagnosis. The Board of the Lupus Foundation of Southern Arizona may request supporting information from the attending physician, limited to this diagnosis, including consultation reports. Successful applicants will be published in Board proceedings, and names may be released to the public in news releases.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Lupus Foundation of Southern Arizona. I understand that the revocation will not apply to information that has already been released in response to this authorization unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order for my application to be considered. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 (2015.) I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____

Signature of Patient / Parent / Guardian or Authorized Representative /Date (Guardian or Authorized Representative must attach documentation of such status.)

_____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

LUPUS FOUNDATION OF SOUTHERN ARIZONA

ATTESTATION that the APPLICANT or FAMILY MEMBER NAMED ABOVE, has been diagnosed with SYSTEMIC LUPUS ERYTHEMATOSIS:

Health Care Provider Name: _____

Signed: _____ Date: _____