ARIZONA HIPAA MEDICAL RELEASE FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize _____ to disclose the following information
(Name of clinic, individual, etc.)

from the health records of:

_____ _____ / _____ /_____
Name (Please print first/last name) Date of Birth (MM/DD/YY)

(_____)_____
Phone Number

_____
Street Address

_____ _____
City / State / Zip E-mail Address

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

_____
Name (Please print)

_____
Address

_____ (_____)_____
City / State / Zip Phone Number

_____
E-mail Address

Please continue to page 2.

HPP Use Only:
HIPAA Privacy Program

INFORMATION TO BE RELEASED (check as applicable):

□ Allergy Records □ Consultations □ Developmental/Behavioral □ Discharge Summary
□ Drug/Alcohol Treatment □ Genetic Testing □ HIV/AIDS □ History & Physical
□ Hospital Records & Reports □ Immunizations □ Surgical Reports □ Laboratory Reports
□ Prescriptions □ Psychiatric □ Sexual Assault □ Sexually Transmitted Disease
□ Treatment or Tests □ X-Ray Reports □ Other Communicable Disease
□ Other (Specify):

- OR –

□ ENTIRE RECORD **excluding** the following (CIRCLE as applicable):

¯ Sexually Transmitted Disease ⌋ HIV/AIDS ⊏ Other Communicable Diseases | Genetic Testing

⊓ Developmental/Behavioral Health Care/Psychiatric Care ⌈ Treatment of Alcohol and/or Drug Abuse

☐ Information about Child Abuse/Neglect

FOR THE FOLLOWING DATE(S) OF SERVICE:

From (MM/DD/YYYY): _____ / _____ / _____ To (MM/DD/YYYY): _____ / _____ / _____

PURPOSE FOR DISCLOSURE (Check applicable categories):

□ Treatment □ Research □ Medical Hardship Waivers □ Legal Investigation or Action
□ Insurance Eligibility/Benefits □ Other (Specify):

Please continue to page 3.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

SIGNATURE: _____ DATE: _____

Description of Authority to sign if personal/legal representative:

_____

IDENTITY OF REQUESTOR VERIFIED VIA: □ Photo ID □ Matching signature □ Other: _____