

## 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.*

Form B: HIPAA Privacy Program  
HIPAA Authorization

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.*

**Form B: HIPAA Privacy Program  
HIPAA Authorization**

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:

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IDENTITY OF REQUESTOR VERIFIED VIA:  Photo ID  Matching signature  Other: \_\_\_\_\_