

# 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:

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

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

- OR -

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

- |  |                                   |   |  |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> Sexually Transmitted Disease                          | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other Communicable Diseases            | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> Developmental/Behavioral Health Care/Psychiatric Care |                                   | <input type="checkbox"/> Treatment of Alcohol and/or Drug Abuse |  |
| <input type="checkbox"/> 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):

- |   |                                   |   |  |
|---|-----------------------------------|---|--|
| <input type="checkbox"/> Treatment  | <input type="checkbox"/> Research | <input type="checkbox"/> Medical Hardship Waivers | <input type="checkbox"/> Legal Investigation or Action |
| <input type="checkbox"/> Insurance Eligibility/Benefits <input type="checkbox"/> Other (Specify): |                                   |   |  |

*Please continue to page 3.*

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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: \_\_\_\_\_