ARIZONA DEPARTMENT OF HEALTH SERVICES

Arizona State Hospital

Civil and Forensic Facilities

2500 East Van Buren Street

Phoenix, Arizona 85008

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient name: _____

Address: _____

Phone number: _____ DOB: _____

Social Security Number: _____

I authorize Arizona State Hospital to:

☐Disclose copies of protected health information (PHI)

☐Exchange verbal information

☐Request information

Person/agency: _____

Address: _____

Phone number (if known): _____ Fax number (if known): _____

The admission and discharge periods requested are _____ to _____

(If dates are incomplete, the most current discharge information will be provided.)

Specific description of the information to be disclosed: (**NOTE**: I understand that a release of this information may include information related to AIDS/HIV and other Communicable Diseases, Alcohol and/or Drug Abuse Treatment) _____ Patient Initials

_____ Discharge Summary

_____ History and Physical Exam

_____ X-ray Reports

_____ Lab Tests

_____ Psychiatric Admission Summary

_____ A summary of medical records (History and Physical, Psychiatric Assessment and Discharge Summary) for hospital visits dated: _____

_____ A summary of billing records (cover page of the patient billing statement for each visit for hospital visits dated: _____

_____ Legal Health Record (complete medical record)

_____ Entire Designated Record Set (includes billing records)

_____ Other (specify) _____

Specific description of the purposes of the disclosure:

_____ Continued Patient Care

_____ Workers' Compensation

_____ Insurance Coverage or Payment for Care

_____ Other (specify) _____

_____ The disclosure is at my (the patient's) request.

I authorize the provider to use or disclose information related to (check all that apply):

_____ AIDS/HIV and other Communicable Diseases
_____ Behavioral Health Care/Psychiatric Care/Mental Health Information
_____ Alcohol and/or Drug Abuse Treatment
_____ Genetic Testing Information

The provider will not deny me treatment if I do not wish to sign this form. I understand that I may refuse to sign this authorization form.

I understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the provider's Notice of Privacy Practices (Notice of Privacy Practices is not applicable to patients admitted under forensic commitment)**.**

To revoke my authorization I must submit a written request to the Director of the Health Records Department or sign the section below on the original authorization.

Unless I revoke this authorization earlier, it will expire one year from today's date.

I understand that if this information is disclosed to a third party the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Authority to Act for Patient

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Signature Date