HIPAA Compliant Authorization for Release of Patient Information Pursuant to 45 CFR 164.508

Section I – Patient Information

Name:		Member ID:
Street Address:		Birth Date:
City:	State:	Zip:
Telephone:	Email:	

I, or my authorized representative, hereby authorize Picture Rocks Fire and Medical District and their respective employees to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below.

SECTION II –Authorized Designee (to whom the information will be sent)

Name:		Relationship:
Street Address:		Telephone:
City:	State:	Zip:

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION** only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to Freedom Health. I understand that I may revoke this authorization, except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in Freedom Health, or eligibility benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION II.**

Section III – Specific Information to be Released:

☐ Please release my Medical Record from (insert date) _____ to (insert date) _____.

☐ Please release my entire Medical Record, including patient history of treatment and/or transportation and/or refusal of treatmenat and/or transportation including diagonstic records, medications lists, prior medical history, electrocardiogram tracings and impressions, including any acceptance or refusal of care and/or transportation for the abovementioned date(s).

☐ Please release all billing records including all statements, insurance claim forms, itemized bills, records of billing to third party payers and payment or denial of benefits for the abovementioned date(s).

Reason for release of information:

☐ At the request of the individual

☐ Other: _____

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

Name:		Relationship:
Street Address:		Telephone:
City:	State:	Zip:

By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

_____ _____

Signature of Member or Authorized Representative Date

State of Arizona
County of _____

The foregoing instrument was acknowledged before me this ____day of _____, 20___, at _____, Arizona, by _____ to be his/her free act and deed.

_____

Signature of Notary Public

Name of Notary Public (Print): _____
Notary Public, State of Arizona SEAL
My commission expires: _____