Maricopa Integrated Health System

2601 E. ROOSEVELT • PHOENIX, ARIZONA 85008

Patient Identifier

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

DT7787

☐ Adult Emergency Department fax number: 602-344-5565
☐ Peds Emergency Department fax number: 602-344-5805
☐ Medical Record Department fax number: 602-344-5092
☐ Other: _____

I authorize Maricopa Integrated Health System to disclose protected health information ("PHI") from the health records of:

Patient's Name: _____

Address: _____

Phone Number: _____ Medical Record Number: _____ SSN: _____

Date of Birth: _____ Dates of treatment to be released: _____

SEND RECORDS TO:
Name of person or facility: _____ at

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number (if known) _____ Fax Number (if known) _____

☐ Fax Number Confirmed

Specific description of the information to be disclosed:

_____ Face Sheet
_____ Discharge Summary
_____ History and Physical Exam
_____ Operative Reports
_____ X-ray / Diagnostic Reports
_____ X-ray / Diagnostic Images on Disc
_____ Lab Tests
_____ Pathology Reports
_____ Consultations
_____ Other: (specify) _____

_____ Attending Admission Evaluation
_____ Social Work Evaluation
_____ Nursing Assessment
_____ Treatment Plan
_____ Progress Notes (specify) ☐ Discharge – Last 3 ☐ All
_____ Behavioral Health Assessments / Evaluations

Records to be disclosed in the following format:
_____ Paper
_____ Compact Disc (CD)

Specific description of the purpose of the disclosure:

_____ Continued Patient Care
_____ Disclosure is at patient's request
_____ Workers' Compensation
_____ Other (specify) _____
_____ Insurance Coverage or Payment for Care

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 also 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.

_____

Unless I revoke this authorization earlier, it will expire 90 days from the date signed. I understand the revocation will not apply to information that has already been released in response to this authorization.

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.

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 redisclosed by the person/organization that receives the information.

Patient Signature | Printed Name | Date | Time

Legal Representative Signature | Printed Name | Relationship to Patient or Description of Authority to Act for Patient