

PIMA COUNTY HEALTH DEPARTMENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Description of Purpose for Release: Patient Request ____ Or Other Reason (Describe Below):

INFORMATION REQUESTED FROM:

NAME:			
ADDRESS:			
CITY:	STATE:	ZIP CODE:	TELEPHONE:

SEND MEDICAL INFORMATION TO:

NAME:			
ADDRESS:			
CITY:	STATE:	ZIP CODE:	TELEPHONE:

PATIENT INFORMATION:

FIRST NAME:	MIDDLE:	LAST NAME:	BIRTH DATE:
ADDRESS:			
CITY:	STATE:	ZIP CODE:	TELEPHONE:
MOTHER'S MAIDEN NAME:		MR#:	

INFORMATION REQUESTED:

PATIENT TO INITIAL AREAS TO BE RELEASED:		
<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> LAB RESULTS	<input type="checkbox"/> DRUG/ALCOHOL	
<input type="checkbox"/> X-RAYS	<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> TREATMENT PLAN	<input type="checkbox"/> PSYCHIATRIC	
<input type="checkbox"/> FAMILY PLANNING	<input type="checkbox"/> COLPOSCOPY	
<input type="checkbox"/> STD	<input type="checkbox"/> WIC	

I UNDERSTAND THAT THIS MEDICAL INFORMATION MAY INCLUDE INFORMATION RELATING TO THE FOLLOWING AND I AGREE TO ITS RELEASE UNLESS I INDICATE NO.

YES ___	NO ___	AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME) OR HIV (HUMAN IMMUNODEFICIENCY VIRUS)
YES ___	NO ___	BEHAVIORAL HEALTH CARE
YES ___	NO ___	TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE
YES ___	NO ___	GENETIC COUNSELING, TESTING

I understand that a covered agency may not condition treatment, payment, enrollment or eligibility upon obtaining this authorization, except where federal law allows such condition.

I understand that if the agency authorized to receive the health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure.

This authorization may be revoked in writing at any time, except to the extent that action has been taken based upon the authorization. Instructions for revocation are contained in the Pima County Health Department Notice of Privacy Practices. This authorization will expire one year from today's date, or upon the following date or event: _____

SIGNATURES:

PATIENT:	DATE OF SIGNATURE:
LEGALLY AUTHORIZED REPRESENTATIVE:	
RELATIONSHIP TO PATIENT:	