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:

__________HISTORY/PHYSICAL	__________PROGRESS NOTES	__________OTHER:________________________
__________LAB RESULTS	__________DRUG/ALCOHOL	
__________X-RAYS	__________HIV/AIDS	
__________TREATMENT PLAN	__________PSYCHIATRIC	
__________FAMILY PLANNING	__________COLPOSCOPY	
__________STD	__________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:	