PINAL COUNTY PUBLIC HEALTH SERVICES DISTRICT
HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: _____Date of Birth: _____

Address: _____Telephone:_____

I authorize:

PINAL COUNTY PUBLIC HEALTH SERVICES DISTRICT
Phone: 1-866-960-0633

Apache Junction Clinic	Casa Grande Clinic	Coolidge Clinic	Eloy Clinic	Kearny Clinic
575 N Idaho Rd, Ste 301	1729 N Trekell Rd, Ste 120	119 W Central	302 E 5th St	355 Alden Rd
Apache Junction, AZ 85119	Casa Grande, AZ 85122	Coolidge, AZ 85128	Eloy, AZ 85131	Kearny, AZ 85137
Fax: (520) 866-6165	Fax: (520) 866-7490	Fax: (520) 866-7964	Fax: (520) 866-7689	Fax: (520) 363-5968

Mammoth Clinic	Maricopa Clinic	San Tan Valley Clinic	Superior Clinic
110 Main St	41600 W Smith-Enke Rd,	36235 N Gantzel Rd	60 E Main St
Mammoth, AZ 85618	Bldg 15	San Tan Valley, AZ 85142	Superior, AZ 85173
Fax: (520) 487-2463	Maricopa, AZ 85138	Fax: (520) 866-4696	Fax: (520) 689-2618
	Fax: (520) 866-4646		

To use and release, and to disclose protected health information (PHI) for use to:

_____

_____

The information to be disclosed is (Client must initial each item to be provided, including other):

_____History & Physical	_____Pathology Report	_____X-ray Reports
_____Discharge Summary	_____Laboratory Report	_____Psychiatric Testing
_____Operative Reports	_____EKG Reports	_____Other (describe below)

Other:

PCPHSD Staff Signature: _____

Comments: _____
_____

In addition to the above, I specifically authorize the disclosure of medical records or information. If any, related to diagnosis, treatment and prognosis regarding the following (client must initial next to each):

_____Mental condition and/or treatment including psychotherapy notes;
_____Drug or alcohol abuse and/or treatment; or
_____HIV or AIDS or AIDS related complex condition and/or treatment

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CONDITIONS:

1. The Patient/Member authorizes Pinal County to use and disclose his/her confidential healthcare information only for the purposes listed above:

2. The Patient/Member authorizes the entity(ies) organizations(s) listed above to access and receive his/her confidential information for the purposes listed above;

3. The information that is authorized to be released may no longer be protected under federal privacy laws once it is used and disclosed as described above;

4. Upon request, Pinal County will provide the patient/member (or their Personal Representative) with a copy of the confidential healthcare information for which this authorization is being sought subject to restrictions in 45 CFR 164.524;

5. The Patient/Member (or their Personal Representative) is voluntarily signing this authorization;

6. The Patient/Member (or their Personal Representative) reserves the right to refuse to sign this authorization. Pinal County will not withhold treatment to anyone who refuses to sign this authorization;

7. The Patient/Member (or their Personal Representative) reserves the right to revoke this authorization at anytime. This revocation must be in writing and may be submitted to the Privacy Officer for the Pinal County Division named above. It is possible this authorization may not be revoked as requested if the information has already been used or disclosed, or the authorization was obtained as a condition of obtaining insurance coverage.

8. The Patient/Member (or their Personal Representative) will receive a copy of the signed authorization, upon request;

9. This authorization will be maintained for a minimum of 6 years.

10. If Pinal County Division is requesting this authorization for its own use, or to disclose information maintained by Pinal County to another provider or agency, in some cases information will be used for direct or indirect remuneration to Pinal County.

This authorization is in effect from _____to_____ (expiration of time or expiration of an event). Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the Patient/Member's confidential healthcare information is permitted beyond that date.

_____ _____

Signature of Patient/Member or Patient's Authorized Representative Date

If signed by the Patient/Member's Personal Representative, please print name and describe relationship to the patient, and authority to act as person representative:

_____ _____

Name (please print) Relationship