

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

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

I authorize:

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

**Pinal County Public Health Services District
Phone: 1-866-960-0633**

<u>Apache Junction Clinic</u> 575 N Idaho Rd, Ste 301 Apache Junction, AZ 85119 Fax: (520) 866-6165	<u>Casa Grande Clinic</u> 1729 N Trekell Rd, Ste 120 Casa Grande, AZ 85122 Fax: (520) 866-7490	<u>Coolidge Clinic</u> 119 W Central Coolidge, AZ 85128 Fax: (520) 866-7964	<u>Eloy Clinic</u> 302 E 5 th St Eloy, AZ 85131 Fax: (520) 866-7689	<u>Kearny Clinic</u> 355 Alden Rd Kearny, AZ 85137 Fax: (520) 363-5968
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<u>Mammoth Clinic</u> 110 Main St Mammoth, AZ 85618 Fax: (520) 487-2463	<u>Maricopa Clinic</u> 41600 W Smith-Enke Rd, Bldg 15 Maricopa, AZ 85138 Fax: (520) 866-4646	<u>San Tan Valley Clinic</u> 36235 N Gantzel Rd San Tan Valley, AZ 85142 Fax: (520) 866-4696	<u>Superior Clinic</u> 60 E Main St Superior, AZ 85173 Fax: (520) 689-2618
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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: Continuity of care

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