AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I authorize_____("Facility") to disclose protected health information (PHI) contained in or made a part of the health records of:

Patient name:_____
Date of Birth:_____ Social Security Number (if required):_____
Mailing address:_____
City/Town:_____State_____Zip:_____
Phone: Area Code:_____Number:_____

To the following person or entity:
Name: Jacqueline Shore-RN Patient Advocates of Arizona, PLLC_____
Mailing address: P.O. Box 31954_____
City/Town: Phoenix_____State AZ_____Zip: 85046
Phone: Area Code: 602 Number: 465-2733_____Fax: 602-795-0749
☐ Copy of Death Certificate ☐ Copy of Medical Power of Attorney ☐ Copy of appointment as personal representative attached, if required by the facility.

Specific description of the information to be disclosed:
Date of Service:_____

☐ Discharge Summary	☐ Laboratory tests	☐ Other:_____
☐ History and Physical	☐ Radiology Reports	_____
☐ Operative Reports	☐ Consultations	_____

Specific description of the purpose of the disclosure:

☐ Continued patient care	☐ Insurance Coverage/Payment for care
☐ Worker's Compensation	☐ Other:_____

I authorize the provider to use or disclose information related to (check all that apply):
☐ AIDS/HIV and other communicable diseases
☐ Behavioral Healthcare/Psychiatric Care/ Mental Health Information
☐ Alcohol and/or Drug Abuse Treatment
☐ Genetic Testing Information

I may refuse to sign this authorization form. I understand that the Facility will not deny me treatment if I do not decide to sign this form. I also understand that I may revoke this authorization at any time, unless the facility has relied on this authorization and already released the information. **Unless I revoke this authorization earlier, it will expire in one year from the date signed.** To revoke my authorization, I must submit a written request to the medical records custodian at the applicable facility:
_____
_____
_____

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 re-disclosed by a third party.

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.

_____ _____
Signature of Patient/Patient's Legal Representative Date

_____ _____
Print above name Relationship to Patient