Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Phone _____

I authorize _____ to disclose protected health information to:

Name _____ Phone _____ Fax # _____

Address _____ City _____ State _____ Zip _____

☐ Call this phone number when records are available for pick up at clinic _____

PURPOSE FOR USE/DISCLOSURE _____

Approximate date(s) of service to be used/disclosed: _____

INFORMATION TO BE USED / DISCLOSED

- ☐ Discharge summary
- ☐ History and Physical
- ☐ Consultation report(s)
- ☐ Other _____
- ☐ Pathology report
- ☐ Lab reports
- ☐ Radiology reports/films
- ☐ EKG report(s)

Specific Authorization to Disclose Sensitive Records I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: (please check and initial)

- ☐ Alcohol and/or drug abuse records *Initials* _____
- ☐ Sexually transmitted disease information *Initials* _____
- ☐ Psychiatric records *Initials* _____
- ☐ HIV/AIDS information *Initials* _____

*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that _____ _____ has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Privacy Officer, at 117 Seaboard Lane, Bldg E, Franklin, TN 37067 or fax 615-467-1270, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing and dating this form, unless otherwise documented here: _____
- I understand that _____ may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be "covered entity" protected by the Federal privacy law, if the recipient is not.

☐ If box is checked, the clinic will receive direct or indirect financial compensation in connection with the use or disclosure of your information for marketing purposes.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

_____ _____

Signature (Patient or Patient's Legal Representative) Date

_____ _____

Printed Name of Legal Representative Relationship to Patient

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

Physician Group
OF ARIZONA, INC.

Patient Label