

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

**NAME OF PATIENT OR INDIVIDUAL**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
**OTHER NAME(S) USED** \_\_\_\_\_  
**DATE OF BIRTH** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_  
 \_\_\_\_\_  
**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**PHONE** \_\_\_\_\_ **ALT. PHONE** \_\_\_\_\_  
**EMAIL ADDRESS (Optional):** \_\_\_\_\_

**I AUTHORIZE ARIZONA BREAST HEALTH SPECIALISTS TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:**

Person/Organization Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

**WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?** Can we disclose your information to your: spouse, adult child(ren), sibling, or other person? If yes, please write their name, contact information and relationship to you.

Person/Organization Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

**REASON FOR DISCLOSURE:**

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other \_\_\_\_\_

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> <b>All Health Information</b> | <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Billing Information |
| <input type="checkbox"/> History/Physical Exam         | <input type="checkbox"/> Patient Allergies    | <input type="checkbox"/> Discharge Summary       | <input type="checkbox"/> Radiology Reports   |
| <input type="checkbox"/> Past/Present Medications      | <input type="checkbox"/> Operative Reports    | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Imaging Films       |
| <input type="checkbox"/> Lab Results                   | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports       | <input type="checkbox"/> Other _____         |

**Your initials are required to release the following information:**

\_\_\_\_\_ Mental Health Records (excluding psychotherapy notes) \_\_\_\_\_ Genetic Information (including Genetic Test Results)

\_\_\_\_\_ Drug, Alcohol, or Substance Abuse Records (excluding Part 2) \_\_\_\_\_ HIV/AIDS Test Results/Treatment

*Your initial at this location serves as specific consent to disclose the above described protected information. You acknowledge that this information, once disclosed, may lose its protected status and be subject to redisclosure.*

**YOU HAVE A RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION**



**EFFECTIVE TIME PERIOD:** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **Arizona Breast Health Specialists, ATTN: Privacy Officer.** I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosures permitted or required by law or have occurred through my prior authorization, and that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE X** \_\_\_\_\_ DATE \_\_\_\_\_  
Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable): \_\_\_\_\_

If representative, specify relationship to the individual:  Parent of minor  Guardian  Other \_\_\_\_\_

*Proof of legal authority as representative may be requested in advance of disclosure of records.*

**SIGNATURE X** \_\_\_\_\_ DATE \_\_\_\_\_  
Signature of Minor Individual

**Delivery Method:**  Mail  Email  Pickup Date: \_\_\_\_\_

**Format requested:**  Paper  Electronic media  CD (Only for Imaging)

Records will automatically be mailed 10 days after pick-up date. (Initial) \_\_\_\_\_

**Rejection of Encryption of Email or Electronic Media:**

Unencrypted electronic media requested  Unencrypted Email Requested

If electronic delivery of records is requested, either by electronic media or email, delivery shall be made by a secure encrypted method. If you chose to decline secure delivery, your election to receive the records through an unencrypted method serves as acknowledgment of the risks associated and waiver and release of Arizona Breast Health Specialists, its parent and subsidiary companies, affiliated entities, directors, officers, employees and agents ("Released Parties") against any and all claims, now or in the future, relating to the unsecure delivery of your health record information.