Authorization to Release Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PATIENT NAME: ____________________ DATE OF BIRTH: ______________ ACCOUNT #: ____________

SECTION 1: **I hereby authorize Comprehensive Integrated Care to disclose/release (check all that apply):**

- ◻ Operative Reports
- ◻ Progress Notes
- ◻ Laboratory Results
- ◻ HIV Lab Results*
- ◻ Medication Summary
- ◻ Immunization Record
- ◻ Nursing Documentation
- ◻ Photos
- ◻ Billing/Payment Record
- ◻ Correspondence
- ◻ Diagnostic Imaging Report(s): ____________
- ◻ Diagnostic Images (on CD): ____________
- ◻ Other (specify): ____________________________

*Note HIV related information is not disclosed unless specifically authorized.

To the following person(s), facility, or entity: **From Service Date** __________ **to** ________

____
Name

______________ ______________ ______________
Phone # **Fax #** **Email**

____
Address **City** **State** **Zip Code**

Method of Delivery (Check One): ◻ **Mail** ◻ **Fax** ◻ **Email** ◻ **Pick Up in Person (State issued ID required)**

This Authorization Expires (Check One): ◻ **1 year** ◻ **6 months** ◻ **Other:** ______________

Purpose of Release (Check all that apply): ◻ **Personal** ◻ **Continuing Care** ◻ **Legal** ◻ **Other:** __________

I understand that after Comprehensive Integrated Care (CiC), the custodian of the records, discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked of specified, this authorization will expire 1 year from date of signature. *You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 8475 E Hartford Dr. Ste 201, Scottsdale, AZ 85255.*

______________________________ ______________
Signature of Individual (Person whom the Information Relates) Date of Signature
– OR –

______________________________ ______________
Signature of Patient Representative Date of Signature

______________________________ ______________
Printed Name of Patient Representative Relationship to Patient

SECTION 2:

Medical Record Release

Authorization Verified By (Print): ____________________ **Date of Release:** ____________

◻ All Items requested released ◻ Exceptions: ____________________

For Records Picked Up in Person:

I understand that after Comprehensive Integrated Care (CiC), the custodian of the records, discloses the requested information, it may no longer be protected by federal and/or state privacy laws. I acknowledge that I have received the records indicated above.

______________________ ______________________ __________
Name of Individual Records Released To (Print) Signature Date

______________________ ______________________
State/Federal ID # Witness Signature