Maricopa County
Department of Public Health
Division of Clinical Services

MEDICAL RECORD #
_____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the Maricopa County Department of Public Health to disclose the following information from the health record of:

_____ _____
Patient Name Date of Birth

Please mark the records being requested:

☐ Laboratory Results* ☐ HIV Lab Results * ☐ Immunization Records ☐ Progress Notes
☐ Correspondence ☐ Medication Summary ☐ X-Ray Report ☐ X-Ray Films (on Disc)
☐ Payment Record ☐ Photos ☐ Referrals ☐ Other (Specify): _____

***Note: HIV-related information is not subject to disclosure unless specifically authorized**

From Service Date: _____ **to**_____

Purpose for Release: ☐ Personal Use ☐ Legal Purpose ☐ Continuation of Care ☐ Other:_____

Please select method of delivery:
☐ **Fax** ☐ **Mail** ☐ **Pick-Up (person picking up records will need to show picture ID)**

_____
Company/Person/Facility

_____
Address City State Zip

_____ _____
Phone Number Fax Number

- I understand that MCDPH will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, unless MCDPH has already relied on my authorization to disclose health information to the agency named above. To revoke my authorization, I must submit a written request to the MCDPH Compliance and Risk Manager, 4041 N. Central Ave., Suite 1400, Phoenix, AZ 85012.
- I understand that, if this information is disclosed to the agency, the information may no longer be protected by the federal or state privacy law and may be re-disclosed by that agency. I understand the matters discussed on this form. I release MCDPH, its employees, officers and directors, medical staff members, and agents from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- Unless I revoke this authorization earlier, **it will expire 6 months from the date signed** or as specified: _____.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description of Authority

State of _____ } ss This instrument was acknowledged before me this

County of _____ _____ by _____

_____
Notary Public

My commission will expire _____

ID Verified by:_____ ROI Completed by: _____

Date: _____ Date:_____