Authorization for Use or Disclosure of Protected Health Information

Member's Name:	**Date of Birth:** __ / __ / ____
AHCCCS ID:	**CIS ID:**
Member Address:	

I, or my Authorized Representative, request the release health information regarding my care and treatment as set forth in this authorization. In accordance with Arizona state law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 CFR Part 2, I understand the following:

1. **Voluntary Authorization**. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
2. **Redisclosure**. Information disclosed to a third party under this authorization may no longer be protected by state or federal law and might be redisclosed by the recipient, ***with the following exceptions***: If I authorize the release of information related to alcohol/drug abuse, communicable diseases (including HIV/AIDS), genetic testing (and information derived therefrom), or medical records or payment records, the recipient is prohibited from redisclosing the information without my authorization, unless permitted to do so under federal or state law. *See* 42 CFR Part 2, A.R.S. § 36-664(G), A.R.S § 12-2802(F), and A.R.S. § 12-2294(E).
3. **Specific Authorizations**. Disclosure of information relating to alcohol/drug abuse, mental health treatment (except psychotherapy notes), communicable disease information (including HIV/AIDS), and genetic testing (and information derived therefrom) requires specific authorization. ***By placing my initials on the appropriate line(s) in the Specific Authorizations below,*** I specifically authorize the release of such information to the person(s) indicated below.
4. **Revocation**. I have the right revoke this authorization, except to the extent that action has already been taken based on this authorization. I must send any revocation in writing to the person or entity permitted to disclose the information.
5. **Fees**. If I am requesting this information for myself or third party, I may be assessed appropriate and reasonable fees for the copying of such information. Any fees will comply with all state and federal laws.

Name person(s), organization, or program permitted to disclose the information:

Name and address of person(s) or organization(s) to whom this information is to be disclosed:

Purpose of Disclosure: ☐ Member's Request ☐ Other:

Specific Information to be Released (*check appropriate box(es)*):
☐ Medical Records from (*insert start date*) ___________________ to (*insert end date*) ___________________.
☐ Entire Medical Record, including patient history, office notes (except psychotherapy notes), referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: ____

Specific Authorizations *(Release of any of the following types of information **requires your initials below**):*

_______ Alcohol/Drug Abuse Records
_______ Genetic Testing and Related Information
_______ Communicable Disease Info (including HIV/AIDS)
_______ Mental Health Records (except psychotherapy notes)
NOTE: Psychotherapy notes require a separate authorization form.

Unless revoked, this authorization expires 12 months from date signed unless I specify another Event or Date here:
____

Signature (Member or Authorized Representative*). ___________________________________ Date __ / __ / ____

**If signed by someone other than Member, please specify authority for signing and provide supporting documentation.*