Phoenix Children's

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Apply Patient Label

Patient Name: _____ Date of Birth: _____/_____/_____
First Middle Last *Month Day Year*

Other Names Used: _____ Medical Record Number: _____
(If applicable) *(If known)*

I authorize Phoenix Children's to ☐ **Release Records To**: ☐ **Obtain Records From:**

Recipient/Organization: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____ Email: _____

Information to be released by: ☐ Secure Email – PDF ☐ Electronic Sharing - Radiology Imaging ☐ Fax

Purpose of the release is: ☐ Continued Medical Care ☐ Personal Use ☐ Legal ☐ Insurance
☐ Disability ☐ School ☐ Other (specify): _____

Type of Records:
☐ Hospital/Inpatient ☐ Outpatient/Specialty Clinic: _____
☐ Emergency Department/Urgent Care ☐ Phoenix Children's Pediatrics: _____ (specify location)

Records for Dates:

From **To**

_____ -- _____
Month/Year **Month/Year**

If no date is specified, we release the most recent record.

☐ Discharge Summary ☐ Outpatient Clinic Progress Notes
☐ History & Physical ☐ Radiology & Other Diagnostic Reports
☐ Operative Report/Procedure Note ☐ Radiology & Other Diagnostic Images
☐ Lab Results/Pathology Report ☐ Billing Statements
☐ Immunizations ☐ Other: _____

I understand that there may be sensitive information contained in my medical record for which I give my authorization to release:
My signature on this form authorizes the release of the specified information below. (please indicate type of records you authorize to be released; information not indicated will not be released.)

☐ Sexually Transmitted Diseases (HIV/AIDS/Other) ☐ Genetic Information ☐ Mental Health/Biobehavioral

Notice: Any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

My Rights - I understand that:

- This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time, with some exceptions, by informing the Health Information Management department in writing. The revocation will take effect once received by the Health Information Management Department.
- I understand that once the information has been released to the recipient according to the terms of this authorization, the information may be re-disclosed

Expiration of Authorization: This authorization expires six (6) months from the date signed unless another date or event is indicated here: _____

_____ _____
Signature of Patient/Legally Authorized Representative Date

_____ _____
Printed Name of Patient/Legally Authorized Representative Relationship to Patient

After completing the above information, please fax, email, or mail this form to:
Phoenix Children's /Attn: ROI
1919 E Thomas Road Phoenix, AZ, 85016
Fax: 602-933-2469
HIMRecordRequests@phoenixchildrens.com

For Phoenix Children's Use Only:

Have the records been released to the requestor? ☐ Yes ☐ No Staff Name: _____ Dept: _____