



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Apply Patient Label

Below are a number of questions we need answered in order to release your Protected Health Information (PHI). The form also includes information about your rights related to the release of PHI. Please complete all areas on the form and if you have questions, please contact the Health Information Management Department (Medical Records at 602-933-1490 Option 1).

<i>Patient Name</i> _____	<i>Date of Birth</i> _____	<i>Phone Number</i> _____
<i>Address</i> _____	<i>City</i> _____	<i>State</i> _____
<i>Zip</i> _____		

<b>I authorize the information to be disclosed by:</b>  PHOENIX CHILDREN'S HOSPITAL Individual/Entity Name: _____  1919 E THOMAS ROAD PHOENIX, AZ 85016 Address: _____  602-933-1490                      602-933-2469 Phone:                                      Fax: _____  Email: <a href="mailto:himrecordrequests@phoenixchildrens.com">himrecordrequests@phoenixchildrens.com</a>	<b>I authorize the information to be disclosed to:</b>  Individual/Entity Name: _____  Address: _____  Phone:                                      Fax: _____  Email: _____
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**Purpose of the release is:**  Continued Medical Care  Disability  Attorney's Office  Personal Use of Records  School  Insurance  Other (state reason): \_\_\_\_\_

**Type of Records (MUST COMPLETE BELOW)**

Cardiology Clinic  Arizona Pediatric Eye Specialists  Urology Clinic  Pediatric Surgeons of Phoenix  
 Plastic Surgery  Phoenix Children's Primary Care  Hospital/Clinics  Emergency Department/Urgent Care

**Date(s) of Service:** \_\_\_\_\_

**Type of Documents to be Released:**

<input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Emergency Department Report <input type="checkbox"/> Progress Notes <input type="checkbox"/> Pathology Report <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Immunization Record	<input type="checkbox"/> Consultations (indicate physician) _____ <input type="checkbox"/> Radiology & Other Diagnostic Reports <input type="checkbox"/> Radiology & Other Diagnostic Images <input type="checkbox"/> EKG Reports <input type="checkbox"/> Billing Statements <input type="checkbox"/> Other: _____ <input type="checkbox"/> Specific Physician: _____
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I understand that the above health records may include information which requires specific permission for release. I authorize the provider to use or disclose information related to **(check and initial all that apply)**.

	Yes	No	N/A	Initials
Sexually Transmitted Disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acquired Immunodeficiency Syndrome (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Human Immunodeficiency Virus (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Communicable Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuropsychology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genetic Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol and/or Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____





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**Notice:** Phoenix Children’s Hospital and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal 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, provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Phoenix Children’s Hospital receives it, except to the extent that Phoenix Children’s Hospital or others have already relied on it. For more detailed information on when I can and cannot revoke this Authorization, I can read the Phoenix Children’s Hospital Notice of Privacy Practices. I am entitled to receive a copy of this Authorization.

**Expiration of Authorization:** Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_ . If I fail to specify an expiration date, event or condition, this authorization **will expire automatically six (6) months from the date signed.**

I understand the matters discussed on this form. I release Phoenix Children’s Hospital, its employees, agents, officers, directors and medical staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Information to be released by (Please Choose **ONE**):  Secure Email - Electronic (PDF)  Patient Portal (FMH)  Fax

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Date & Time

\_\_\_\_\_  
Printed Name of Patient or Legally Authorized Representative (LAR)

\_\_\_\_\_  
Relationship to Patient

**After Completing the Above Information, please fax, email or mail this form to:**

**Phoenix Children’s Hospital/Attn: ROI  
1919 E. Thomas Rd Phoenix, AZ 85016  
FAX: 602-933-2469**

**Email: HIMRecordRequests@phoenixchildrens.com**

<b>For PCH Use only:</b>	
Completed by Employee & Department: _____	Date/Time: _____
<input type="checkbox"/> Requester ID Verified	<input type="checkbox"/> Request entered in ROI Software
Medical Record Number _____	Account Number _____