PHOENIX CHILDREN'S Hospital

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

Patient Name	Date of Birth	Phone Number
Address	City	State / Zip

I authorize the information to be disclosed by:	**I authorize the information to be disclosed to:**
Individual/Entity Name:	Individual/Entity Name:
Address:	Address:
Phone: Fax:	Phone: Fax:

Purpose of the release is: ☐ Continued Medical Care ☐ Disability ☐ Attorney's Office ☐ Personal Use of Records ☐ School ☐ Insurance ☐ Other (state reason):_____

Date(s) of Service: _____

Type of Information to be Released:

☐ **Discharge Summary**	☐ **Outpatient Clinic** _____
☐ **History & Physical Report**	☐ **Radiology & Other Diagnostic Reports**
☐ **Operative Report**	☐ **Radiology & Other Diagnostic Images (CD of images)**
☐ **Emergency Department Report**	☐ **EKG Reports**
☐ **Progress Notes**	☐ **Billing Statements**
☐ **Pathology Report**	☐ **Other:**_____
☐ **Laboratory Reports**	☐ **Other:**_____
☐ **Immunization Record**	
☐ **Consultations (indicate physician)**_____	

I understand that the above health records may include information which require specific permission for release. I authorize the provider to use or disclose information related to **(check and initial all that apply).**

	Yes	No	Initials
Sexually Transmitted Disease (STD)	☐	☐	_____
Acquired Immunodeficiency Syndrome (AIDS)	☐	☐	_____
Human Immunodeficiency Virus (HIV)	☐	☐	_____
Other Communicable Diseases	☐	☐	_____
Behavioral HealthCare/Psychiatric Care	☐	☐	_____
Genetic Information	☐	☐	_____
Alcohol and/or Drug Abuse	☐	☐	_____

DTROIREQ

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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.

_____ _____

Signature of Patient or Legally Authorized Representative | Date/Time

_____ _____

Printed Name of Patient or Legally Authorized Representative | If signed by Legally Authorized Representative, List your relationship

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

Phoenix Children's Hospital
1919 E. Thomas Rd
Phoenix, AZ 85016
Attn: ROI
FAX: 602-933-1477

For PCH Use only:

Completed by Employee & Department:_____ Date/TIme:_____

☐ Requester ID Verified ☐ Request entered in ROI Software

Medical Record Number _____ Account Number _____

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