ARIZONA DEPARTMENT OF HEALTH SERVICES

POLICY & INTERGOVERNMENTAL AFFAIRS

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____

Address: _____

Phone number: _____ Email address:_____

Purpose of Disclosure: _____

As a preliminary matter, the Arizona Department of Health Service (ADHS) is not a medical provider, is not the custodian of personal medical records, and does not maintain a medical records repository.[1]

ADHS does receive *limited* medical records in its capacity as a regulator. Please select below the type of protected health information you are authorizing for release:

- ☐ Arizona State Hospital medical records
- ☐ Newborn Screening
- ☐ Office of Infectious Diseases (HIV/AIDS, etc.)
- ☐ Immunizations (please complete Immunization Record Request Form)
- ☐ Records related to an ADHS investigation
- ☐ Other (specify) _____

I acknowledge, and hereby consent to such, that the released information may contain confidential HIV/AIDS and other Communicable Diseases, and information related to Mental Health and/or Alcohol/Drug Use. _____ (Initial)

I hereby authorize ADHS to release/disclose all of the above-requested information relative to my treatment and care to:

Person/agency/organization: _____

Address: _____

Phone number: _____ Email address: _____

PHI to be disclosed is from date: _____ to _____.

[1] Entire medical record files must be requested from the specific medical provider or facility that provided the medical care.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient

[2]State of _____ County of _____

On this _____ day of _____, 20_____ before me personally appeared _____, whose identity was proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this document and who acknowledges that they signed the above document.

Notary Signature _____ My commission expires _____

Notary Seal

[2] If this authorization is not notarized, please submit a copy of the patient or representative's government-issued identification, which bears their signature, as well as a copy of a legal document that verifies their legal authority to sign on behalf of the patient (e.g. birth certificate, power of attorney, proof of legal guardianship, etc.).