



Health Information Management Department  
 1919 E. Thomas Road  
 Phoenix, AZ 85016-7710  
 Phone: (602) 546-1490  
 Fax: (602) 546-1477

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ MRN \_\_\_\_\_

1. I authorize the use and disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:  
 Phoenix Children's Hospital and Phoenix Children's Ambulatory Clinic(s)  
 1919 E. Thomas Rd.  
 Phoenix, AZ 85016

This information may be disclosed to and used by the following individual or organization:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

For the purpose of:  Further Medical Care  Disability  Legal  Personal Use  School  
 Insurance  Other: \_\_\_\_\_

The type and amount of information to be disclosed is as follows: (include dates where appropriated)

- Ambulatory/Clinic Record**  
**Date(s) of Treatment:** \_\_\_\_\_
- Pertinent Medical Record Information
  - Initial Examination
  - Consultations (indicate physician)
    1. \_\_\_\_\_
    2. \_\_\_\_\_
    3. \_\_\_\_\_

- Problem List
- Immunization Record
- Progress Notes
- Laboratory Reports
- Other \_\_\_\_\_
- RADIOLOGY**  CD  FILM

- PCH Inpatient Record**  
**Date(s) of Treatment:** \_\_\_\_\_
- Pertinent Medical Record Information
  - Discharge Summary
  - History & Physical
  - Operative Report
  - Pathology Report
  - Consultations
  - Progress Notes
  - Laboratory Reports (dates) \_\_\_\_\_
  - X-ray Reports (dates) \_\_\_\_\_
  - Diagnostic reports:  
 EEG  EKG  EMG
  - Other \_\_\_\_\_

I do  I do not  authorize the "facsimile transmittal" of health information.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 on which it was signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

\_\_\_\_\_  
 Signature of Patient or Legal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 If signed by Legal Representative,  
 Relationship to Patient

\_\_\_\_\_  
 Signature of Witness

\*If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign.