

# Maricopa County's Authorization to Use and Disclose Protected Health Information

I authorize Maricopa County Employee Benefits Division to release/disclose protected health information (PHI) regarding:  
(Please Print Legibly)

1	Name of individual:	Employee ID #:
	Alternative ID # or Social Security Number:	Date of Birth:

Name of person/organization authorized to receive the protected health information. (PHI):

2	<input type="radio"/> Employee Benefits Division	<input type="radio"/> County Department Liaison:
	<input type="radio"/> Other:	

3	Relationship of individual to employee: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent <input type="radio"/> Other
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4	PHI to be disclosed is from date: _____ through date _____
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5	Specific Description of the PHI to be disclosed: <input type="checkbox"/> Claims for date the service beginning _____ and ending _____ Name of Medical Provider: _____ Amount of Charges: \$ _____ Authorization/Pre-certification/Referrals from referring physician: _____ Date of referral/admission _____ Type of Service: _____
	<input type="checkbox"/> Confidential HIV and AIDS-related information
	<input type="checkbox"/> Confidential Alcohol or Drug Abuse-related information
	<input type="checkbox"/> Confidential Genetic Testing information
	<input type="checkbox"/> Confidential Communicable Disease-related information <input type="checkbox"/> Confidential Mental Health Diagnosis/Treatment information <input type="checkbox"/> Other: _____

6	The purpose of the disclosure of PHI is to resolve an issue regarding:
	<input type="radio"/> Being billed incorrectly <input type="radio"/> Claim not paid/paid incorrectly <input type="radio"/> Eligibility/Enrollment/Insurance Coverage
	<input type="radio"/> Collections <input type="radio"/> Continued Patient Care <input type="radio"/> The disclosure is at the individual's request
	<input type="radio"/> Other:

7	Provide a brief description of what action you are requesting to be taken:
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With respect to all information other than HIV and AIDS-related information, this authorization will expire on the earlier of 365 days after the date of this signature or the date when I no longer am employed by Maricopa County or on following date:  
With respect to HIV and AIDS-related information, this authorization will expire 6 months from the date of signing.

I understand that the covered entity (the provider, health plan or health care clearinghouse) may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that after this information is disclosed, the HIPAA federal law might not protect it and the recipient might re-disclose it.

## SIGNATURE/RIGHT TO REVOKE

8	I hereby release anyone disclosing or receiving the records or information specified above pursuant to this authorization from any and all liability arising from that disclosure. I understand that I have the right to revoke this authorization at any time by notifying Maricopa County's Employee Benefits Division in writing at 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003, except for any information that has already been released.
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9	Individual's Signature: _____ Date: _____
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Note: If PHI requested is regarding a spouse, the spouse must sign in the Individual's Signature section above.

If the individual is unable to give consent because of physical condition or age, complete the following:  
Individual is a minor ( \_\_\_\_\_ years of age), or is unable to give consent because:

10	Signature of Parent/Guardian/Power of Attorney: _____	Description of Authority to Act for Individual: _____
	Relationship to Individual: _____	

**Prohibition of Redisclosure:** If the information disclosed relates to substance abuse treatment, the confidentiality of these records is protected by federal law. Federal regulations (42 CFR Part 2) prohibit any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rule restricts any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient records.

Please note, you are entitled to receive a copy of this authorization form. You may fax a copy of this form to the Employee Benefits Division at 602-506-2354, however, a signed original authorization form is required for our records.

For Office Use: <input type="checkbox"/> Requested original faxed form on ___/___/___ Name of County Employee releasing PHI: _____
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