

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

Identity of patient authorizing the release/disclosure of protected health information (PHI). Please Print Legibly

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):

<input type="checkbox"/> Employee Health Initiatives Benefits Office	<input type="checkbox"/> County Department Liaison: _____
<input type="checkbox"/> Other: _____	

PHI to be disclosed is regarding <input type="checkbox"/> Self <input type="checkbox"/> Spouse: _____	<input type="checkbox"/> Dependent _____	<input type="checkbox"/> Other _____
PHI to be disclosed is from date ___/___/___ through date ___/___/___		

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: \$ _____
<input type="checkbox"/> 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 Communicable Disease-related information
<input type="checkbox"/> Confidential Alcohol or Drug Abuse-related information	<input type="checkbox"/> Confidential Mental Health Diagnosis/Treatment information
<input type="checkbox"/> Confidential Genetic Testing information	<input type="checkbox"/> Other: _____

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

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

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 Health Initiatives Division in writing at 301 W. 4th Ave., Suite B100, Phoenix, AZ 85003, except for any information that has already been released.
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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 \_\_\_\_\_

Signature of Parent/Guardian/Power of Attorney: _____	
Relationship to Individual: _____	Description of Authority to Act for 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 Employee Health Initiatives 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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This authorization reflects the requirements of 45CFR§164.508.