

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

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.	Employee Benefits Division	County Department Liaison:
	Other:	

3.	PHI to be disclosed is regarding	Self	Spouse:	Dependent:	Other:
	4.	PHI to be disclosed is from date		through date	
5.	Specific Description of the PHI to be disclosed:				
	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:		
	Confidential HIV and AIDS-related information		Confidential Communicable Disease-related information		
Confidential Alcohol or Drug Abuse-related information		Confidential Mental Health Diagnosis/Treatment information			
Confidential Genetic Testing information		Other:			

6.	The purpose of the disclosure of PHI is to resolve an issue regarding:		
	Being billed incorrectly	Claim not paid/paid incorrectly	Eligibility/Enrollment/Insurance Coverage
	Collections	Continued Patient Care	The disclosure is at the individual's request
	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:

This authorization reflects the requirements of 45CFR§164.508.
 Revision Date: 10/17/11