

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

I, _____, authorize _____ to disclose Protected Health Information ("PHI") from the below named Patient's health record.

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____ Social Security #: _____

Date(s) of Treatment/Care requested: _____ to _____; _____ to _____.

ALL records without exception.

PARTIAL/SPECIFIC records as noted below:

	Admission & Discharge Records		History and Physical Report		Physician's Orders
	Billing/Invoices		Laboratory		Progress notes
	Consultation Reports		Nurses' notes		Social Services
	Diagnostic Imaging Reports		Operative Report		Therapy (OT/PT/Resp)
	Discharge Summary		Pathology Report		
	Emergency Room Records		Pharmacy		

DIAGNOSTIC FILMS as noted below:

I understand and authorize the release of records that may contain confidential HIV/AIDS related information (as defined in A.R.S. 36-661), confidential communicable disease related information, or information relating to mental health and/or alcohol/drug use (42 C.F.R. Part II).

I understand that I may revoke this authorization at any time, with some exceptions, that being to the extent the health care provider has acted on this authorization prior to the date they receive the letter to revoke authorization. To revoke my authorization, I must submit a written request to the health care provider named in this release.

This authorization will **expire** on the following date, event, or condition: _____.

The purpose of this request is personal.

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of PHI. It is my understanding that if the person or entity that receives my medical records is not a health care provider or health plan covered by the federal privacy regulations my medical records may be re-disclosed and no longer protected by these regulations.

DATE: _____

Signature of patient or legal representative

Relationship to patient or description of authority to a act for patient

Address of Legal Representative

Telephone Number of Patient or Legal Representative

AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF ARIZONA)
) ss.
COUNTY OF MARICOPA)

Re: _____ (Patient name)
DOB: _____
SSN: _____

1. I am a duly authorized Custodian of Records, and have authority to certify the records.

2. The attached copy is a true copy of all of the records described in the Subpoena and
 comprises _____ pages.

3. The records were prepared by personnel or persons acting under the control of either, in
 the ordinary course of office business at or near the time of the act, condition or event
 described therein.

I declare under penalty of perjury that the foregoing is true and correct.

DATED this _____ day of _____, 2004.

Custodian of Records

(Organization)

(Address)
