PHOENIX CHILDREN'S Hospital®

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Apply Patient Label

Below are a number of questions we need answered in order to release your Protected Health Information (PHI). The form also includes information about your rights related to the release of PHI. Please complete all areas on the form and if you have questions, please contact the Health Information Management Department (Medical Records at 602-933-1490 Option 1).

_____ _____ _____

Patient Name *Date of Birth* *Phone Number*

_____

Address *City* *State* *Zip*

I authorize the information to be disclosed by:

Individual/Entity Name:

Address:

Phone: Fax:

Email: _____

I authorize the information to be disclosed to:

_____

Individual/Entity Name:

_____

Address:

_____ _____

Phone: Fax:

Email: _____

Purpose of the release is: ☐ Continued Medical Care ☐ Disability ☐ Attorney's Office ☐ Personal Use of Records ☐ School ☐ Insurance ☐ Other (state reason):_____

¶

Type of Records (MUST COMPLETE BELOW)

☐ **Cardiology Clinic** ☐ **Arizona Pediatric Eye Specialists** ☐ **Urology Clinic** ☐ **Pediatric Surgeons of Phoenix**
☐ **Plastic Surgery** ☐ **Phoenix Children's Primary Care** ☐ **Hospital/Clinics** ☐ **Emergency Department/Urgent Care**

Date(s) of Service: _____

Type of Documents to be Released:

☐ **Discharge Summary**
☐ **History & Physical Report**
☐ **Operative Report**
☐ **Emergency Department Report**
☐ **Progress Notes**
☐ **Pathology Report**
☐ **Laboratory Reports**
☐ **Immunization Record**

☐ **Consultations (indicate physician)_____**
☐ **Radiology & Other Diagnostic Reports**
☐ **Radiology & Other Diagnostic Images**
☐ **EKG Reports**
☐ **Billing Statements**
☐ **Other:_____**
☐ **Specific Physician: _____**

I understand that the above health records may include information which requires specific permission for release. I authorize the provider to use or disclose information related to **(check and initial all that apply).**

	Yes	No	N/A	Initials
Sexually Transmitted Disease (STD)	☐	☐	☐	_____
Acquired Immunodeficiency Syndrome (AIDS)	☐	☐	☐	_____
Human Immunodeficiency Virus (HIV)	☐	☐	☐	_____
Other Communicable Diseases	☐	☐	☐	_____
Psychiatric Care	☐	☐	☐	_____
Psychology	☐	☐	☐	_____
Neuropsychology	☐	☐	☐	_____
Genetic Information	☐	☐	☐	_____
Alcohol and/or Drug Abuse	☐	☐	☐	_____

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Notice: Phoenix Children's Hospital and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

My Rights: I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time, with some exceptions, provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Phoenix Children's Hospital receives it, except to the extent that Phoenix Children's Hospital or others have already relied on it. For more detailed information on when I can and cannot revoke this Authorization, I can read the Phoenix Children's Hospital Notice of Privacy Practices. I am entitled to receive a copy of this Authorization.

Expiration of Authorization: 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 signed**.

I understand the matters discussed on this form. I release Phoenix Children's Hospital, its employees, agents, officers, directors and medical staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Information to be released by (Please Choose **ONE**): ☐ Secure Email – Electronic Records (PDF)/Powershare – Electronic Radiology Images ☐ Patient Portal (FMH) ☐ Fax

_____ _____
Signature of Patient or Legally Authorized Representative Date & Time

_____ _____
Printed Name of Patient or Legally Authorized Representative (LAR) Relationship to Patient

After Completing the Above Information, please fax, email or mail this form to:
Phoenix Children's Hospital/Attn: ROI
1919 E. Thomas Rd Phoenix, AZ 85016
FAX: 602-933-2469
Email: HIMRecordRequests@phoenixchildrens.com

For PCH Use only:

Completed by Employee & Department:_____ Date/Time:_____

☐ Requester ID Verified ☐ Request entered in ROI Software

Medical Record Number _____ Account Number _____