SIERRA TUCSON®

Authorization To Disclose Healthcare Information

Patient Full Name:_____ DOB _____ Social Security# **XXXX-XX-** _ _ _ _

Phone Number: _____ Address: **On File**

I hereby authorize: ☒ release information to ☒ Exchange Information

NAME: Sierra Tucson
ADDRESS: 39580 S. Lago Del Oro Parkway
Tucson, Arizona 85739
PHONE: 520-624-4000
FAX: 520-818-5897 Medical Records

Name: _____
Address: _____
_____
Email: _____ phone#_____
relationship: _____ fax# _____

By signing below, I hereby authorize Sierra Tucson or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex, including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.
Disclosure shall be limited *to* the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

The following information is requested: (patient*or legal guardian X items to be released).

___ Psychiatric Evaluation
___ History & Physical
___ Practitioner Orders
___ Practitioner Progress Notes
___ Discharge Summaries
___ Assessments
___ Laboratory Reports
___ Immunization Records
___ Medication Records
___ Treatment/Individualized Service
___ Plan Discharge Instructions
___ Test Results/Reports
___ Financial Account Information/insurance documents
___ Progress Notes
___ Psychological Report
___ Other (specify)_____
_____

The Purpose or Need for Disclosure is:

___ To Transfer Patient Care
___ For Follow Up Care
___ To Inform Family
___ Referral Source
___ Legal/Court System
___ Legal Purposes
___ To Aid in Treatment
___ For Discharge Planning
___ To Update Medical Records
___ Employer
___ Continuing Care
___ Personal Use
___ Application for Provider Coverage
___ Telephone/Written Communication about TX, Progress & Concerns
___ To Aid in financial account activity
___ Emergency Contact (Medical, AMA, Psychiatric, Transfer, Administrative)
___ Other (specify)_____

I understand that the information in my health record may include information relating *to* sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ***State and federal law protect the following information. If this information applies to you, please ('1') indicate if you would like this information released/obtained*** (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	X Yes	__ No	**Admit· Discharge**
HIV Testing and Results	__ Yes	X No	**Admit· Discharge**
Mental Health Records Dates	X Yes	__ No	**Admit· Discharge**

Disclosure Format (Paper/US Mail, Fax or Email is default if not marked) Specify other Electronic if not marked_____

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or **180 days days from date of signature. (date cannot be more than 180 days after date signed below)**

- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation **will** not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.
- I understand that Sierra Tucson will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release Sierra Tucson, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

Patient or Authorized Representative Signature	Print Name Relationship to Patient (if applicable).	Date	Time
Witness Signature	Print Name of Witness	Date	Time

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R. part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.
Updated 11/2015, 02/2018