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

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	X **Yes**	__ **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