SIERRA TUCSON

# *Authorization to Disclose Healthcare Information*

☐ **Tucson** ☐ **Scottsdale** ☐ **Southlake**

By completing and signing this form I authorize my records to be released as noted below. All records sent by email will be sent securely using encryption unless otherwise requested. Due to the risk that information could be potentially intercepted or altered in transit, Sierra Tucson strongly recommends using encryption or a secure link to transmit patient records in order to promote the confidentiality and integrity of patient information. Sierra Tucson will only send records via unencrypted/unsecure channels upon patient request. **All sections on both pages must be completed for authorization to be considered valid.**

**Patient Info**

| | | | |
|---|---|---|---|
| Patient Full Name: | | Address: | |
| | | | City: State: Zip: |
| Phone Number: | DOB: | Email: | |

**Release To/Delivery Method**

I hereby authorize: Sierra Tucson to: ☐ release information to ☐ exchange information with ☐ release information to myself

| | |
|---|---|
| Name: | Address: |
| Phone Number: | Fax Number: |
| Relationship: | Email Address: |

Please select delivery method below (NOTE: if the recipient designates an alternative delivery method we will comply to the best of our ability.)

☐ Paper via US mail ☐ Email (please ensure email is listed) ☐ Fax ☐ FedEx

**Information to Release**

The following information is requested (check mark by each item to be released):

| | | | |
|---|---|---|---|
| ☐ Discharge Summaries | ☐ Laboratory Reports | ☐ Practitioner Orders | ☐ Immunization Records |
| ☐ History & Physical | ☐ Medication Records | ☐ Practitioner Progress Notes | ☐ Financial Account Information |
| ☐ Psychiatric Evaluation | ☐ Plan Discharge Instructions | ☐ Treatment Plans | ☐ Other: _____ |
| ☐ Assessment/Consults | ☐ Psychological Report | ☐ Progress Notes | ☐ Other: _____ |

**Purpose**

The Purpose or Need for Disclosure is (select all applicable options):

| | | | |
|---|---|---|---|
| ☐ To Transfer Patient Care | ☐ Legal/Court System | ☐ Employer | ☐ Telephone/Written Communication about TX, Progress & Concerns |
| ☐ For Follow Up Care | ☐ Legal Purposes | ☐ Continuing Care | ☐ To Aid in Financial Account Activity |
| ☐ To Inform Family | ☐ Insurance | ☐ Personal Use | ☐ Emergency Contact (Medical, AMA, Psychiatric, Transfer, Administrative) |
| ☐ Referral Source | ☐ To Update Medical Records | ☐ Application for Provider Coverage | ☐ Other: _____ |

**Patient Authorization**

I understand that the protected health information released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about my behavioral or mental health services and treatment I have received for drug and alcohol abuse if those categories are applicable to me.

**Revoking (cancelling) authorization**: I may revoke (cancel) this authorization at any time. Revocations (cancellations) will not apply to information that has already been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself. **This authorization will expire on _____. If no date is included, the authorization will expire 6 months from the date of signature.**

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a healthcare provider or health plan covered y federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing substance use disorder information under the federal confidentiality requirements for substance abuse patient records as Federal Law 42 CFR Part 2 prohibits unauthorized disclosure of these records. Such information may not be used to criminally investigate or prosecute a substance abuse patient. Further, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization is voluntary. I understand that Sierra Tucson will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document.

**Sign**

| | | | |
|---|---|---|---|
| _____<br>Patient or Authorized Representative Signature | _____<br>Print Name Relationship to Patient (if applicable) | _____<br>Date | _____<br>Time |
| _____<br>Witness Signature | _____<br>Print Name of Witness | _____<br>Date | _____<br>Time |

**Return To**