Patient Authorization for Release of PHI

Federal Law states that your healthcare provider cannot share or request your protected health information (PHI) without your authorization *except* for treatment, payment and healthcare operations. You can identify in writing a person or entity that you would like us to share your information with and we will accommodate all reasonable requests.

Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. Thus, this form should be used to identify anyone authorized to receive your health information until a Power of Attorney becomes effective.

Please complete the below information (any section that is left blank may delay our response to your request)

Patient Name (Print): _____ DOB: _____

Phone (home or mobile): _____ Date of Request: _____

I hereby authorize (select one) □ AKDHC □ PKDHC to disclose my protected health information described below to (print name): _____

Authorized Person's Relationship to me:
□ Family Member □ Friend □ Other (identify relationship) _____

□ The identified person is also authorized to participate in any appointment and billing activities related to my care.

I am authorizing the above person to have access to the following information:
□ All past, current and future information found in my records.
□ All records from the start date of _____ thru _____
□ Only records checked below from the start date of _____ thru _____
□ Billing Records □ Visit Notes □ Lab Results □ Radiology Results □ Procedure Reports
□ Other (list all that apply): _____

Purpose of authorization (select one):
□ At the request of the individual signing this form (i.e. per your request).
□ Continuity of Care (if authorizing us to provide your health information to another treating physician).
□ Other: _____

Expiration of Authorization

I understand that this authorization will expire as indicated below (select one)
□ One year from the date of this authorization.
□ On the following date: _____

- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Privacy Office (in writing) at the address noted at the bottom of this form. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.
- I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.

Patient or Legal Representative **Printed** Name

Patient or Legal Representative **Signature**

Date

All Authorization requests should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer
3333 East Camelback RD Suite 180
Phoenix, AZ 85018

Phone: 602-997-0484

Revoking an Authorization:

Requests to revoke this Authorization must be made in writing. Please contact the Privacy Office using the contact information above to obtain an Authorization Revocation form.

OFFICE USE ONLY:			
Request Received By:		Date:	