AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFOMATION

Federal Law states that your healthcare provider cannot release or request your protected health information (PHI) without your authorization *except* for treatment, payment and healthcare operations. You can authorize in writing that you want your PHI released to an individual or entity.

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

PATIENT INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Date of Birth	Phone		
COMPLETE THIS SECTION TO AUTHORIZE AKDHC/PKDHC TO *RELEASE* YOUR PHI TO AN IDENTIFIED INDIVIDUAL OR ENTITY	**COMPLETE THIS SECTION TO AUTHORIZE AKDHC/PKDHC TO *REQUEST* YOUR PHI FROM AN IDENTIFIED INDIVIDUAL OR ENTITY**		
Name:	Name:		
Address:	Address:		
Phone:	Phone:		
Fax:	Fax:		

I am authorizing the release/request of the below 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.

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.

______________________________	______________________________
Patient or Legal Representative **Printed** Name	Patient or Legal Representative **Signature**

____
Date

If the above signature is the patient's Legal Representative complete the following:

LEGAL REPRESENTATIVE INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Representative capacity (e.g. power of attorney, legal guardian, executor of estate):	Phone		

Submitting an Authorization Request Form:

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

OFFICE USE ONLY:			
Request Received By:		Date:	