Authorization to Release and Disclose Medical Records

PATIENT NAME___________________________________DATE OF BIRTH ____________

ADDRESS ____

DISCLOSING AGENCY OR INDIVIDUAL____

ADDRESS____

PHONE____

I hereby authorize and consent to the release and disclosure, by the above-named agency or individual, of medical records, hospital records, billings, doctor reports, x-rays, x-ray reports, diagnostic films, prescription orders, medication charts, admission/discharge summaries, records and reports regarding psychiatric treatment, testing and evaluation, records and reports regarding drug and alcohol abuse, HIV/communicable disease records and any medical information whatsoever arising from my care and treatment at any time. Disclosure shall be made to the company or person or their representative listed below or to the bearer of this instrument.

Name and Address of Company or persons authorized to receive this information:

Housing Authority of Maricopa County
8910 N. 78th Avenue
Peoria, AZ 85345

I agree that a photocopy of this authorization may be used for all purposes the same as the original.

I understand that the provider from whom I am requesting records has complied with the HIPAA requirements by producing my medical records in accordance with this authorization and is not responsible for any redisclosure of my records by the recipient and will no longer be protected by state or federal regulations. (45CFR§164.508(c)(1)(vi)).

This authorization is in effect for six (6) months from the date of this document. (45CFR§164.508(c)(1)(iv)).

The undersigned may revoke this authorization at any time by providing written notice of revocation to my medical provider. However, the undersigned may not revoke the authorization retroactively for information already released.

____ ______________________

SIGNATURE OF PATIENT OR AUTHORIZED PARTY DATE OF CONSENT

____ ______________________

WITNESS RELATIONSHIP TO PATIENT