MARICOPA COUNTY
CORRECTIONAL HEALTH SERVICES

Maricopa County
Correctional Health Services
Health Information Management Services
234 N. Central Avenue, Suite 5400
Phoenix, Arizona 85004
P: 602-506-3509 F: 602-372-8575

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, #_____, _____, hereby authorize
PATIENT NAME | BOOKING No. or SS No. | DATE OF BIRTH

Name: _____ to disclose the following specific protected health information from the date range of
Name of FROM facility

(DD/MM/YYYY) Date: _____ to (DD/MM/YYYY) Date: _____ to this specified

Name: _____ Email: _____ Phone: _____
(PLEASE PRINT CLEARLY & LEGIBLY) (PLEASE PRINT CLEARLY & LEGIBLY)

Description of information to be disclosed:

____ **ALL** Electronic Health Records on file (within date range above)

**** Health records related to communicable disease, HIV conditions, alcohol, drug abuse, behavioral health, mental health and treatment must be selected below and the patient must sign this release as verification of their personal consent to release these protected health records. [45 C.F.R. 164.508©(1)(i)]**

____ **Communicable Disease / HIV Related Information**
____ **Alcohol or Drug Abuse Related Information**
____ **Behavioral Health / Mental Health Diagnosis / Treatment Information**

Or

Select Specific Records Below (within date range above)

____ Intake Health Assessment & Receiving Screening
____ Release/Transfer Summary
____ Chronic Care & Progress Notes
____ Consult Notes
____ Hospital/Outside Records
____ Medication Records
____ Imaging Reports
____ Clinical Photos
____ Dental (including x-rays)
____ OB Records
____ Lab Tests
____ (Other) _____

REQUIRES PATIENT SIGNATURE:
____ **Behavioral Health/Mental Health Diagnosis/Treatment Info**
____ **Communicable Disease-Related Information**
____ **Alcohol or Drug Abuse-Related Information**

Released patients may obtain a one-time printout of current immunizations and eye exam prescription for community transition purposes at no cost.

_____ TB/PPD Only _____ Eye Exam Prescription

Describe the noncriminal purposes of the disclosure if other than criminal investigation or prosecution:

_____ Continued Patient Care _____ Compassionate Release _____ Other (specify) _____

- I understand that I may revoke this authorization by writing to Correctional Health Services Health Information Management, at any time, except to the extent that action has been taken in reliance upon it. This authorization will expire three-hundred-sixty-five (365) days after the date of this signature.
- I understand that Correctional Health Services may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. 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 privacy regulations.
- I understand I may refuse to sign this authorization.
- I understand the matters discussed on this form. I release Correctional Health Services, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Date _____ Signature of Patient _____ Witness _____

If Patient is unable to give consent because of physical condition or age, complete the following:

Patient is a minor (____ year of age), or is unable to give consent because _____

Date _____ Signature of Parent/Guardian/POA _____

Relationship _____ Witness _____

PROHIBITION OF RE-DISCLOSURE: If the information disclosed relates to substance abuse treatment, the confidentiality of these records is protected by federal law. Federal regulations (42 CFR Part 2) prohibit any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rule restricts any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient records.

Fees: ELECTRONIC COPIES: Flat Fee of $6.50 for standard requests for records maintained and sent electronically. PAPER COPIES: $10.00/first 10 pages and $0.50/page for additional pages produced.

Office use only: The fee for the records you requested is $_____ for _____ pages. Please send a cashier's check, business check or money order payable to MARICOPA COUNTY CORRECTIONAL HEALTH SERVICES. No personal checks will be accepted.