AURORA
BEHAVIORAL HEALTH SYSTEM

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, (*PATIENT NAME*) _____, hereby voluntarily authorize the disclosure of information from my medical record.
The admission and discharge periods requested are: _____ to _____
- If left incomplete, the most current discharge information will be provided.
- For an active admission, I understand that this authorization is valid for release of information covering the entire admission until discharge.

II. The information is to be disclosed by:

☐ Aurora Behavioral Health System - West
6015 W. Peoria Ave., Glendale, AZ 85302
Tel: 623-344-4439 Fax: 623-344-4447

☐ Aurora Behavioral Health System - East
6350 S. Maple Avenue, Tempe, AZ 85283
Tel: 480-345-5400 Fax: 480-345-5451

- Please allow 5-7 business days for processing.
- Extra time may be required for retrieval from storage

And is to be provided to:

NAME OF PERSON/ORGANIZATION/FACILITY _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE # _____

FAX #/EMAIL _____

☐ ***Mailed*** ☐ ***I will pick-up*** ☐ ***Exchange verbal information*** ☐ ***Faxed (abstract only)*** ☐ ***Secure Email***

III. The purpose or need for this disclosure is:

☐ Academic/School ☐ Armed Forces/Military ☐ Continuing Care ☐ Employment
☐ Placement/Aftercare ☐ Legal ☐ Personal Use ☐ Other:

IV. The information to be disclosed from my medical record: check appropriate box(es)

☐ Discharge Paperwork ☐ Initial Assessments ☐ History & Physical ☐ Psychiatric Evaluation
☐ Medication Reconciliation ☐ Laboratory Report ☐ Billing Statements ☐ TB record
☐ Physician Progress Notes ☐ Other:

V. I understand that the information to be disclosed may include information about medical, psychiatric, drug and/or alcohol, mental health, social, and/or communicable diseases, including HIV/AIDS. I request the following limitations:
DO NOT DISCLOSE:

☐ Alcohol/Substance Abuse Treatment/Referral
☐ Sexually Transmitted Diseases
☐ HIV/AIDS – related treatment

PATIENT SIGNATURE _____ DATE _____ TIME _____

VI. I understand that I may revoke this authorization at any time, by submitting in writing to the Health Information Management Department, except to the extent that action has been taken. This authorization shall remain in effect for **sixty (60) days** from the signature date unless further limitation is set here by the patient or legal representative: _____
(*SPECIFY NEW DATE*)

VII. Your rights regarding release of protected health information (PHI):
- I understand that I may refuse to sign this authorization. My signature is voluntary and treatment or eligibility for benefits is not conditioned upon the execution of this authorization.
- I understand the matters discussed on this form and that I can receive a copy of it. I release the provider and its employees of liability for the disclosure of my information pursuant to this request.
- Your records are protected under the federal regulations governing Confidentiality of Alcohol & Drug Abuse Records (42 CFR. Part 2) which prohibit further disclosure without written consent unless provided for by law or regulation.
- If not subject to federal, state, or HIPAA confidentiality regulations, I am aware that the recipient may re-disclose my PHI without my permission.

PATIENT/RESPONSIBLE PARTY SIGNATURE (*State relationship to patient*) _____ DATE _____ TIME _____

PATIENT ADDRESS _____ PATIENT PHONE NUMBER _____ PATIENT DATE OF BIRTH _____

PARENT CO-SIGNOR/RESPONSIBLE PARTY SIGNATURE _____ DATE _____ TIME _____

WITNESS SIGNATURE (*If signature of patient is a thumbprint or mark*) _____ DATE _____ TIME _____

FOR INTERNAL USE ONLY

PHYSICIAN APPROVAL SIGNATURE (*For patient/representative requests only*) _____ **DATE** _____ **TIME** _____