



Authorization to Release Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PATIENT NAME: _____ DATE OF BIRTH: _____ ACCOUNT #: _____

SECTION 1: I hereby authorize Comprehensive Integrated Care to disclose/release (check all that apply):

- | | | |
|---|---|--|
| ☐ Operative Reports | ☐ Immunization Record | ☐ Diagnostic Imaging Report(s): |
| ☐ Progress Notes | ☐ Nursing Documentation | <hr/> |
| ☐ Laboratory Results | ☐ Photos | ☐ Diagnostic Images (on CD): |
| ☐ HIV Lab Results* | ☐ Billing/Payment Record | <hr/> |
| ☐ Medication Summary | ☐ Correspondence | |
| ☐ Other (specify): _____ | | |

*Note HIV related information is not disclosed unless specifically authorized.

To the following person(s), facility, or entity:

From Service Date _____ **to** _____

Name

Phone #**Fax #**

Email

Address

City

State

Zip Code

Method of Delivery (Check One): ☐ Mail ☐ Fax ☐ Email ☐ Pick Up in Person (State issued ID required)

This Authorization Expires (Check One): ☐ **1 year** ☐ **6 months** ☐ **Other:** _____

Purpose of Release (Check all that apply): ☐ Personal ☐ Continuing Care ☒ Legal ☐ Other: _____

I understand that after Comprehensive Integrated Care (CiC), the custodian of the records, discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked or specified, this authorization will expire 1 year from date of signature. *You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 838 W Elliot Rd. Suite 101, Gilbert, Arizona 85233.*

Signature of Individual (Person whom the Information Relates)

- OR -

Date of Signature

Signature of Patient Representative

Date of Signature

Printed Name of Patient Representative

Relationship to Patient

SECTION 2:

Medical Record Release

Authorization Verified By (Print): _____ Date of Release: _____

- ☐ All Items requested released ☐ Exceptions: _____

For Records Picked Up in Person:

I understand that after Comprehensive Integrated Care (CiC), the custodian of the records, discloses the requested information, it may no longer be protected by federal and/or state privacy laws. I acknowledge that I have received the records indicated above.

Name of Individual Records Released To (Print)

Signature

Date _____

State/Federal ID #

Witness Signature