



MARICOPA COUNTY CORRECTIONAL HEALTH SERVICES
 HEALTH INFORMATION MANAGEMENT
 201 S. 4TH AVE PHOENIX, AZ 85003
 PHONE: 602-876-9168 FAX: 602-253-4931
 E-MAIL: CHSHIMROI@MARICOPA.GOV

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, _____, _____
PATIENT NAME BOOKING No. or SS No. DATE OF BIRTH

Hereby authorize Correctional Health Services (CHS) to disclose the following specific protected health information

from: _____ to _____ at my request to:
(DATE) (DATE or TO PRESENT)

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

Description of information to be disclosed:

Make your selection below: (MARK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> ALL Health Records (within date range above) | <input type="checkbox"/> Clinical Photos |
| <input type="checkbox"/> Intake Health Assessment & Receiving Screening | <input type="checkbox"/> Dental (including x-rays) |
| <input type="checkbox"/> Release/Transfer Summary | <input type="checkbox"/> OB Records |
| <input type="checkbox"/> Chronic Care & Progress Notes | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Consult Notes | <input type="checkbox"/> Communicable Disease-Related Information |
| <input type="checkbox"/> Hospital/Outside Records | <input type="checkbox"/> Alcohol or Drug Abuse-Related Information |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Behavioral Health/Mental Health Diagnosis/Treatment Info |
| <input type="checkbox"/> Imaging Reports | <input type="checkbox"/> Other (specify) _____ |

TB/PPD Only, released patients may obtain a one-time printout of current immunizations for community transition purposes at no cost

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.

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.