Abundant Health Family Practice

6130 N. La Cholla Blvd Suite 240
Tucson, AZ 85741

www.abundanthealthfp.com

Phone: 520.326.1457
Fax: 520.326.1464

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

______________________________ Patient's Full Name ______/________/__________ Date of Birth (______)__________-____________ Daytime Phone Number

I authorize Abundant Health Family Practice

TO: __Send/Disclose information __Receive information from: __Discuss with:

Name: ______________________________ **Phone:** (_____) __________-______________

Address: ______________________________ **Fax:** (______) _________-_______________

City: ____________________ **State:** ______________ **Zip:** ______________

For the following purpose(s):

☐ Consultation ☐ Provider Transfer ☐ Personal ☐ Insurance ☐ Worker's Compensation ☐ Legal/Attorney ☐ School

☐ **Other:** ______________________________ **Request for Decedents Information: Date of Death**: _______/_______/___________

Type of information requested:

☐ Complete Record ☐ Immunizations ☐ Office/Progress Note(s) ☐ Consultations
☐ Operative Report ☐ Medication Records ☐ Itemized Billing Records ☐ Radiology Report(s)
☐ History & Physical ☐ ER Report(s) ☐ Laboratory Report ☐ Other ___________

Dates of care to be released: ________________________ **To** ____________________________

I UNDERSTAND THAT:

- **A fee for the cost of processing this request may be charged. At your request, we will provide you a copy of this form.**
- **I understand that my healthcare will not be affected if I do not sign this form.**
- **I hereby authorize Abundant Health Family Practice to use/disclose my individually identifiable health information as described below (which may include photographs and/or information concerning treatment for drug/alcohol abuse, mental health, HIV/AIDS status, or genetic testing, if applicable).**
- **I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations and may be re-disclosed.**
- **Abundant Health Family Practice may utilize a trusted business associate/authorized agent to assist in fulfilling this request.**
- **I can revoke this authorization at any time by submitting a request in writing to the Health Information Services department at Abundant Health Family Practice. This will not apply to any previously released information.**
- **This authorization expires one year from the date of signature, or on: _________________________.**

The following information WILL BE RELEASED unless indicated by your initials below:

Initials: ______ Drug and/or alcohol treatment Initials: ______ Mental health treatment Initials: ______ HIV/AIDS
Initials: ______ Sexually transmitted disease Initials: ______ Genetic testing

_______________________________________ _______________________________
Signature of Patient or Legal Representative/Guardian **Date**

A parent or guardian is generally required to sign for a patient under the age of 18. Patients age 12 to 17 may also be required to sign.

_______________________________ _______________________________________
Printed Name of Patient/Legal Representative **Authority or Relationship of Representative (Attach copy of documentation of authority)**

This information may contain information relating to drug and alcohol treatment that is protected by Federal confidentiality regulations (42 CFR Part 2). Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient**.** 42 CFR § 2.51 (a) Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.