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How to Complete Your Arizona HIPAA Authorization

Authorization for Release of Health Information • 45 C.F.R. § 164.508

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This form lets doctors, hospitals and health plans share your medical information with family members or others you choose. It does not let them make decisions for you; for that, use a Health Care Power of Attorney.

1. **Choose who may release information**
   All of your providers, or only the ones you list.
2. **Name up to three people**
   Each person may receive information separately.
3. **Choose what may be shared**
   Mental health, substance use, HIV and genetic records are shared only if you initial them.
4. **Sign it, and notarize it if needed**
   Many insurers and out-of-state providers prefer a notarized authorization.

Signing requirements: Signed by the patient or a personal representative. Notarization is recommended and often requested.

After It's Signed

- Give copies to each provider and to the people you named.

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Have questions about your HIPAA Authorization? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Arizona • 45 C.F.R. § 164.508

1. PATIENT

Patient full name

Date of birth

Address

Phone

2. WHO MAY RELEASE INFORMATION

☐ Any doctor, hospital, clinic, laboratory, pharmacy, health plan (including AHCCCS) or other covered entity that has treated me or paid for my care.

☐ Only the following provider(s):

3. WHO MAY RECEIVE INFORMATION

I authorize release of my health information to each of the following persons, who may act separately:

Person 1 name | Relationship | Phone

Person 2 name | Relationship | Phone

Person 3 name | Relationship | Phone

4. INFORMATION TO BE RELEASED (check one)

☐ All of my health information, including medical records, test results, billing records, and information about my diagnosis, treatment and prognosis.

☐ Only the following information:

Specially protected information is included **only** if I initial below:

_____ Mental health and behavioral health records (not psychotherapy notes, which need a separate authorization).

_____ Substance use disorder treatment records.

_____ HIV, AIDS and communicable disease information.

_____ Genetic testing information.

5. PURPOSE AND EXPIRATION

Purpose: at my request, to let the persons named above communicate with my providers and help with my care, payment and personal affairs.

This authorization expires on (date or event). If blank, it expires two years from signing.

6. MY RIGHTS

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I may revoke this authorization at any time by written notice to the provider holding my information, except to the extent the provider has already acted in reliance on it. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign. Information released may be redisclosed by the recipient and may no longer be protected by federal privacy rules. A copy of this authorization is as valid as the original.

X _____ Date

Patient signature (or personal representative)

If signed by a personal representative: name and authority (e.g., health care agent, guardian, parent)

ACKNOWLEDGMENT

STATE OF ARIZONA

COUNTY OF

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____ (name(s) of person(s) acknowledging).

X _____

Signature of Notary Public

Notary Public (printed name)

My commission expires

Commission number

(Notary seal)

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