HIPAA Authorization to Use and Disclose Protected Health Information

Patient's Name:		DOB:

AUTHORIZATION

I, or my authorized representative, request the release of health information regarding my care and treatment as set forth in this authorization. In accordance with state law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 CFR Part 2, I understand the following:

1. Voluntary Authorization. Signing this authorization is voluntary. Except for research-related treatment and healthcare intended to create information for disclosure, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

2. Redisclosure. Information disclosed to a third party under this authorization may no longer be protected by state or federal law and might be redisclosed by the recipient, with the following exceptions: If I authorize the release of information related to alcohol/drug abuse, communicable diseases (including HIV/AIDS), genetic testing (and information derived therefrom), or medical records or payment records, the recipient is prohibited from redisclosing the information without my authorization, unless permitted to do so under federal or state law. *See* 42 CFR Part 2.

3. Specific Authorizations. This authorization expressly includes the specific authorizations required for the disclosure of information relating to alcohol/drug abuse, mental health treatment (except psychotherapy notes), communicable disease information (including HIV/AIDS), genetic testing (and information derived therefrom), and developmental disabilities. You may deny specific authorization by placing your initials in the appropriate box(es) in the Specific Authorizations section below.

4. Revocation. I have the right revoke this authorization, except to the extent that action has already been taken based on this authorization. I must send any revocation in writing to the person or entity permitted to disclose the information. If no revocation is made, this authorization will automatically expire twelve (12) months from the date signed. Written notice of revocation must be provided to Midwestern University Clinics, Medical Records Department, 19389 N. 59th Avenue, Glendale, AZ 85308.

5. Fees. If I am requesting this information for myself or third party, I may be assessed appropriate and reasonable fees for the copying of such information. Any fees will comply with all state and federal laws.

DISCLOSING PARTY

Person/Organization/Program:	
Street Address:	
City, State, Zip Code:	
Telephone:	

RECEIVING PARTY

Person/Organization/Program:	
Street Address:	
City, State, Zip Code:	
Telephone:	

PURPOSE

Describe the reason for the disclosure:

INFORMATION TO BE RELEASED

Check as applicable:	ALL CLINICS ☐	Comprehensive Care Clinic ☐	Dental Institute ☐	Eye Institute ☐	Multispeciality Clinic ☐	Therapy Institute ☐

ALL Records ☐	Only Medical Records ☐	Only Billing and Insurance Records ☐	Other (explain):

Date Range (if no range is provided, all records requested will be produced from all times):	

REVOCATION OF SPECIFIC AUTHORIZATIONS

I do **NOT** authorize the release of the following information (initial only if you **do not** want the category of information disclosed):

Alcohol/Drug Abuse Records: *Initial*: ☐	Genetic Testing and Related Info: *Initial*: ☐	Communicable Disease Info (including HIV/AIDS): *Initial*: ☐	Mental Health Records (except psychotherapy notes): *Initial*: ☐	Developmental Disabilities: *Initial*: ☐

SIGNATURE

Patient or Authorized Representative:	**DATE:**

If Authorized Representative, provide basis for authority: