MARICOPA COUNTY CORRECTIONAL HEALTH SERVICES
HEALTH INFORMATION MANAGEMENT
234 N. CENTRAL AVE, STE 5400
PHOENIX, AZ 85004
PHONE: 602-506-3509 FAX: 602-372-8575
EMAIL: 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)

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