ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

NAME OF PATIENT OR INDIVIDUAL:

_____
Last First Middle

DATE OF BIRTH:
Month_____ Day_____Year_____

_____
Address City State Zip

_____ _____ _____
Phone Email Alternate

REASON FOR DISCLOSURE:

☐ Treatment/Continuing Medical Care ☐ Personal Use

☐ Billing or Claims ☐ Insurance ☐ Legal Purposes ☐ Disability Determination

☐ School ☐ Employment ☐ Other _____

I AUTHORIZE ARIZONA BLOOD & CANCER SPECIALISTS TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

Person/Organization Name:_____ Phone: (___)_____
Address:_____ Fax: (____)_____
City:_____ State:_____ Zip: _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? Can we disclose your information to your: Spouse, adult child(ren), sibling or other person? If yes, please write their name, contact information and relationship to you.

Person/Organization Name:_____ Relationship: _____
Address:_____ Fax: (____)_____
City:_____ State:_____ Zip: _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating the items you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the FIRST box.

☐ **ALL HEALTH INFORMATION**	☐ Physicians Orders	☐ Progress Notes	☐ Billing Information
☐ History/physical Exam	☐ Patient Allergies	☐ Discharge Summary	☐ Radiology Reports
☐ Past/Present Medications	☐ Operative Reports	☐ Diagnostic Test Reports	☐ Imaging Films
☐ Lab Results	☐ Consultation Reports	☐ Pathology Reports	☐ Other_____

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING INFORMATION:

____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)

____ Drug, Alcohol or Substance Abuse Records (excluding Part 2) _____ HIV / AIDS Test Results / Treatment

Your initial at this location serves as specific consent to disclose the above-described protected information. You acknowledge that this information, once disclosed, may lose its protected status and be subject to redisclosure.

YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION

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EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month _____ **Day** _____ **Year** _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this authorization, I must send a written request to: **Arizona Blood and Cancer Specialists, (***), ATTN: Privacy Officer.** I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosures permitted or required by law or have occurred through my prior authorization, and that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individuals Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If Representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

Proof of legal authority as representative may be requested in advance of disclosure of records.

SIGNATURE X _____ _____

Signature of Minor Individual DATE

Delivery Method: ☐ Mail ☐ Email ☐ Pickup Date: _____

Format Requested: ☐ Paper ☐ Electronic media ☐ CD (Only for Imaging)

Records will automatically be mailed 10 days after pick-up date. (Initial) _____

REJECTION OF ENCRYPTION OF EMAIL OR ELECTRONIC MEDIA:

☐ Unencrypted Electronic Media Requested ☐ Unencrypted Email Requested

If electronic delivery of records is requested, either by electronic media or email, delivery shall be made by a secure encrypted method. If you choose to decline secure delivery, your election to receive the records through an unencrypted method serves as acknowledgement of the risks associated and waiver and release of Arizona Blood and Cancer Specialists, its parent and subsidiary companies, affiliated entities, directors, officers, employees and agents ("Released Parties") against any and all claims, now or in the future, relating to the unsecure delivery of your health record information.

CHARGES: In accordance with HIPAA, Arizona Blood and Cancer Specialists may charge a reasonable cost-based fee to provide a copy of records requested by you which may include labor for copying the records (but not search and retrieval), supplies for copying on paper or electronic media, postage, and preparation of a summary, if you have agreed to the summary in lieu of the actual record; and in the alternative, if an electronic record was requested and is available, a flat fee of $6.50 including postage and supplies. If the records request was made by someone other than the patient or patient's representative, fees as specified by the state in which the records are located shall apply, if applicable.

Informed of charge for copies (Please Initial) _____