Choices Integrative Healthcare of Sedona
95 Soldier Pass Rd, Suite B, Sedona, AZ 86336
Telephone - 928-203-4844, Fax - 928-203-4497

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name (Last) _____ First _____ MI ____
Date of Birth _____ Social Security Number _____
Mailing Address _____ City _____ State ____ Zip _____
Home Telephone ( )_____ Cell Telephone ( )_____

I hereby authorize _____ to use or disclose my protected health information as indicated below.

Information to be released to:
Name _____
Daytime Phone #_____ Fax # _____
Address _____ City _____ State _____ Zip _____

Information to be released:
Start date:_____ End date:_____

- ☐ History and Physical Exam
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ Consultation Report
- ☐ Other _____

Purpose of Disclosure:

- ☐ Changing Physicians
- ☐ Continuing care
- ☐ At my (patient) request
- ☐ Workers Compensation
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School
- ☐ Other _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information related to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV Related information (including AIDS related testing)

The confidentiality of this record is required under Title 12 of the Arizona Revised Statutes as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in the statutes.

_____ _____ √
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy officer at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance on it.
3. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and no longer be protected by Federal privacy regulations. However, other state and federal lay may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS=related information and psychiatric/mental health information.
4. My healthcare and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization

_____ _____ √
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship to Patient

For Office Use Only:
Date Request Filled _____ by_____ Account #_____
Identification Presented_____ File Code:_____ Fee Collected_____