

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, authorize TMC Health to disclose the protected health information of the above patient, as described below, to the following third parties:

Name(s): \_\_\_\_\_ Name(s): \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

### INFORMATION TO BE DISCLOSED:

I authorize information to be disclosed from the following:

☐ TMC Hospital/Rincon Hospital ☐ TMC One/Other TMC Health Clinic ☐ All TMC Health Facilities

### Specific description of information to be disclosed:

☐ Pertinent Information (H&P, Discharge Summary, Consults, ED Provide notes, EKG, Labs, and Radiology reports)  
☐ Provider Notes ☐ Discharge Summary ☐ Operative Report ☐ Emergency Department Notes ☐ Billing Records  
☐ History & Physical Exam ☐ Lab Results ☐ Imaging Reports ☐ Imaging films on CD  
☐ All Records (last 2 years unless otherwise specified) ☐ Other: \_\_\_\_\_

I authorize the provider to disclose information pertaining to: (check all that apply)

☐ Mental Health ☐ Alcohol and/or Drug Abuse ☐ Communicable Diseases, including HIV/AIDS

Pertaining to health information obtained during: ☐ All past, present, and future periods **OR** ☐ From \_\_\_\_\_ to \_\_\_\_\_

PURPOSE OF DISCLOSURE: ☐ At the request of the patient ☐ Other: \_\_\_\_\_

### YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

**Right to Receive Copy of this Authorization** - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

**Right to Refuse to Sign this Authorization** - I understand that I am under no obligation to sign this form and that TMC Health may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization if such conditioning is prohibited by the Privacy Rule.

**Right to Revoke this Authorization** - I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to TMC Health, Health Information Management Department, 5301 E Grant Road, Tucson, AZ 85712. I am aware that my revocation will not be effective until received by the Health Information Management Department and will not be effective regarding the uses and/or disclosures of my health information that TMC Health has made prior to receipt of my revocation statement.

**Right to Inspect or Copy the Health Information to Be Disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the TMC Health, Health Information Management Department.

**HIV TEST RESULTS:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available.

**REDISCLOSURE NOTICE:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy standards.

**EXPIRATION DATE:** This authorization is valid until (indicate date or event) \_\_\_\_\_.

By signing this authorization, I am confirming that it accurately reflects my wishes. I am also acknowledging that completion of this authorization does not constitute a request for records. **If I wish to request records, I understand that I must also complete a Request for Records form.**

PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE

PRINTED NAME/RELATION TO PATIENT

DATE TIME

**TMC Health – Health Information Management Department**

**Address:** 5301 E Grant Road, Tucson, AZ 85712 **Phone:** (520)324-5166 **Fax:** (520)324-1590

**Email:** tmc.medicalrecordsrequest@tmcaz.com **Website:** tmcaz.com/medical-records



Authorization for Disclosure of Protected Health Information  
HIM ROI Authorization



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