# Arizona Department of Corrections
# Rehabilitation and Reentry

## Authorization for Release of Protected Health Information

| INMATE NAME *(Last, First M.I.) (Please print name)* | ADCRR NUMBER | FACILITY/UNIT |
|---|---|---|
| DATE OF BIRTH *(mm/dd/yyyy)* | SOCIAL SECURITY NUMBER | RELEASE DATE *(mm/dd/yyyy)* |

**RELEASE RECORDS FROM**

Arizona Department of Corrections, Rehabilitation & Reentry
701 East Jefferson St., Phoenix, AZ 85034

**RELEASE RECORDS TO**

| NAME/FACILITY | ATTENTION *(Please print)* | |
|---|---|---|
| ADDRESS *(City, State, Zip Code)* | TELEPHONE NUMBER *(Area Code)* | FAX NUMBER *(Area Code)* |
| E-MAIL | IF FAMILY MEMBER, RELATIONSHIP | |

**THIS SECTION MUST BE FILLED OUT**

I hereby authorize the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) to release the following confidential information to the person or entity named above ***(initial on lines provided if required)***:

- ☐ Current Health Status/Problem List
- ☐ Dental Records
- ☐ Immunizations
- ☐ Consultations *(Outside appointments/Inpatient)*
- ☐ Nurse Encounters
- ☐ Provider Encounters
- ☐ Eyeglasses RX/Optometry
- ☐ Imaging Reports
- ☐ Medication Records
- ☐ Health Needs Requests
- ☐ Refusals/Consents
- ☐ Restricted Diet Order
- ☐ Special Needs Order/Flags

***(Release of the items below requires the inmate's initials.)***

- ☐ Mental Health Treatment *(Initial)* _____
- ☐ Substance Use Disorder *(Initial)* _____
- ☐ Lab Reports *(Initial)* _____ *(see #1 below)*

Records of the period from _____ to _____ , **if dates or details are not provided, copies of records may be limited to 6 months.**

It is understood that copies of records will be provided to the designated individual. An invoice will be issued for any applicable charges.

***I understand that previous records may include any records of mental health or HIV tests results that ADCRR may have received from non-ADCRR providers.**

I understand that these records are protected by various Federal and State laws or regulations, and cannot be disclosed without my written consent unless otherwise provided in the laws or regulations. I hereby release the parties named above from all legal liability that may arise from the release of information requested.

**CONSENT FOR RELEASE**

I, or my authorized representative, request the disclosure of my protected health information as set forth on this form, in accordance with the Health Insurance Portability and Accountability Act of 1996, (HIPAA), I understand that:

1) By initialing Lab Reports (above), the information released or disclosed may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV).

2) I understand that signing this Authorization is voluntary. My treatment or payment for my treatment will not be conditioned upon my authorization for disclosure.

3) I have a right to revoke this Authorization at any time by writing to the health care provider listed above, except to the extent information has been released in reliance upon this Authorization.

4) I understand that the information disclosed pursuant to this Authorization may be re-disclosed to others by the recipient and no longer protected by the federal privacy regulations.

**All relevant provisions of this Authorization have been completed by me and all of my questions have been answered.**

| INMATE'S SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|

| WITNESS NAME *(Last, First M.I.) (Please print name)* | SIGNATURE (*Required Non-Inmate/Non-Family)* | DATE *(mm/dd/yyyy)* |
|---|---|---|