HIPAA RELEASE FORM:
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI) & CONTACT LIST

Patient Name: ______________________________________**DOB**: _______________ **Date**: ___________________

I authorize Sun Valley Arthritis Center, Ltd to use/disclose my personal health information to the individuals on this form __________ Initials

I understand that Sun Valley Arthritis Center, Ltd staff may leave a detailed message on my voicemail. __________ Initials

Contact name: ____ **Relationship:** ______________________________

Address: ______________________________________ **City:** ___________________ **State:** ______ **Zip:** _________

Home Phone: _________________________________ **Cell Phone:** ____

Contact name: ____ **Relationship:** ______________________________

Address: ______________________________________ **City:** ___________________ **State:** ______ **Zip:** _________

Home Phone: _________________________________ **Cell Phone:** ____

- I hereby authorize Sun Valley Arthritis Center, Ltd to use and disclose my personal health information (PHI) to the individuals identified on this form.
- I understand this authorization does not expire unless written notice is mailed to 6818 W. Thunderbird Rd, Peoria, AZ 85381.
- I understand that this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
- I understand that the individuals identified on this form will be treated by Sun Valley Arthritis Center, Ltd as individuals involved directly in my care and as such, Sun Valley Arthritis Center, Ltd will be allowed to release my PHI to these individuals for the purpose of treatment, payment and healthcare operations.
- I have read and received a copy of the above statements and accept these terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to option health care from Sun Valley Arthritis Center, ltd will not be affected if I refuse to sign this authorization.

Health Information Exchange:

- I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the Health Information Exchange of Arizona, or I have previously received this information and decline another copy.

Patient Signature: ____ **Date:** __________________________

Personal Representative Signature: _________________________________ **Date:** __________________________

Relationship to Patient: ____