Arizona Foundation

Print Form

How to return the Form to Arizona Foundation

After filling out this form,
simply click on the "Print" button, and fax or mail it to:

Arizona Foundation
P.O. Box 2909 • Phoenix, AZ 85062-2909

Fax: 602-256-7816

Authorization for Use or Disclosure of Protected Health Information (PHI)

I authorize the use/disclosure of health information about me as described below:

1. Person(s) or class of persons authorized to use/disclose the information:

2. Person(s) or class of persons authorized to receive the information:

3. Description of the information that may be used/disclosed. Your answer must be specific, general authorizations are not allowed. *Example - Specific: "You can talk to my son about my broken leg." Example - General "You can talk to my son about my health."*

4. The information will be used/disclosed for the following purposes
(Note: This item is not required if the disclosure is requested by the patient):

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. If applicable - I understand that the person and/or entity I am authorizing to use/disclose the information will receive compensation for doing so (*Note: This item is not required if the disclosure is requested by the patient*).

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not effect my ability to obtain treatment or payment, or my eligibility for benefits. I may inspect or copy information used/ disclosed under this authorization *(Note: This item is not required if the disclosure is requested by the patient)*.

8. This authorization expires (insert applicable date or event):

Signature of Patient/Representative

Date

Patient's Name (Please Print)

Name of Authorized Representative (If applicable)

Call Center Agent's Name: