INFECTIOUS DISEASE SOUTHWEST
2300 S Houghton Rd Ste 250, Tucson, AZ 85748
Phone: (520) 231-4379 | Fax: (520) 677-4379

HIPAA AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

SSN _____ **Address** _____

City _____ **State** _____ **Zip Code** _____ **Home Phone** _____

Mobile Phone _____ **Email** _____

INFORMATION REQUESTED FROM

Name Infectious Disease Southwest

Address 2300 S Houghton Rd Suite 250 **City** Tucson **State** AZ **Zip Code** 85748

Phone 520- 231-4379 **Fax** 520-677-4379 **Email** info@idsouthwest.com

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SEND INFORMATION TO

Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____ **Fax** _____ **Email** _____

Send by ☐ Email* ☐ Fax ☐ Paper Copy (Pick Up) ☐ Paper Copy (Mail)**

** By electing to receive your health information via email, you understand the risks associated with email communication, including but not limited to the possibility of emails being sent to the wrong address, being read by others, or being stored on servers that are not secure. You agree to provide a valid email address. Infectious Disease Southwest is not responsible for unauthorized access to your health information while in transmission to the email address you designated above.*

***By requesting mailed paper copies of your medical records, you acknowledge that there may be a $6.50 postage and handling fee. This fee covers the cost of securely packaging and sending your records to the specified address, in accordance with Arizona state regulations and HIPAA regulations.*

AUTHORIZATION

This authorization will expire within one (1) year unless otherwise indicated. I understand that this authorization is voluntary and may be revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this form. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

I understand that I must submit a copy of my valid government-issued photo ID along with this completed form for it to be processed. The form will not be processed without this documentation. I understand that this form must be completed in its entirety for the authorization to be valid.

I have read and understand the information provided in this form. By signing below, I authorize the release of my health information as specified above.

Signature _____ **Date** _____

Printed Name _____ **Relationship** _____

YOU MUST PROVIDE A COPY OF PHOTO IDENTIFICATION WITH THIS FORM.
FORM MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST WILL NOT BE PROCESSED