

THE UNIVERSITY OF ARIZONA,
Petersen Clinics Ryan White Program
1501 N. Campbell Ave., Box 245039
Tucson, AZ 85724
Phone: (520) 626-8598 · Fax: (520) 626-6352

Release of Information - By signing this form, I hereby authorize an **Exchange of Information**, concerning the medical history, care and treatment of myself, which is to be shared between medical providers, medical care programs, case workers, funding sources, and those involved in the provision of physical and/or psychological care and financial support. I am aware that my HIV status and possibly chemical, alcohol and psychiatric information will be included. Exchange of information will only occur with those entities on a *need to know basis* for continuity of care, for relaying information to payer sources, to report statistical information to the Department of Health and Health Resource Services Administration. If at any time I feel that my confidentiality has been breached, I may file a grievance by calling the number above.

Client Name _____ Client Signature _____ Date _____

Witness/Staff Member _____ Title _____ Phone _____ Date _____

Last Name: _____ First: _____ M.I. _____
 Nick Name: _____ SS No: _____ - _____ - _____ Date of Birth: ____/____/____
 Address: _____ Mail: Yes No Discreet
 City: _____ State: _____ Zip: _____ County: _____
 Phone: _____ Email/2nd Phone: _____
 Number of dependents in Household: _____

| Monthly Income | | | |
|-------------------------------|----|-----------------------------|----|
| Employment | \$ | Trust Fund/Stock/Properties | \$ |
| General Assistance/TANF | \$ | Unemployment | \$ |
| Retirement/Private Disability | \$ | Spousal Income | \$ |
| Social Security (SSDI/SSI) | \$ | VA Income | \$ |
| Total Monthly Income: | | | |

For Department Use Only: New Update Renewal Denied Reason: _____
 Approval by: _____ Date: _____ Plan Dates: _____ to _____

Documents Attached:



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

| | |
|--------------------------------------------------|----------|
| Organization Who Is Releasing Information | |
| Facility: | |
| Address: | |
| City, State | Zip Code |
| Fax: | Phone: |

| | |
|--------------------------------------------------------|------------------------|
| To Whom Information Will Be Provided | |
| Entity/Individual: Banner University Medical Center | |
| Address: 1501 N. Campbell Ave, PO Box 245039 | |
| City, State Tucson, AZ | Zip Code 85724-5039 |
| Fax: 520-626-6352 | Phone: 520-626-1014 |

| | | |
|-----------------------------|---------------------------|----------------------|
| Patient Information: | Patient Name: _____ | Date of Birth: _____ |
| | Address: _____ | Phone Number: _____ |
| Dates Requested: | FROM: All _____ | TO: _____ |

***There May be a FEE Associated with your Request for Records**

| | | |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Records Being Requested: | Health Center/Clinic Records <input checked="" type="checkbox"/> Office Visit/Progress Note <input checked="" type="checkbox"/> Immunization Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input checked="" type="checkbox"/> Laboratory Report <input checked="" type="checkbox"/> Medication List <input type="checkbox"/> EKG Report <input checked="" type="checkbox"/> Imaging/X-ray Report <input type="checkbox"/> Imaging/X-ray CD/Film <input checked="" type="checkbox"/> Consultation <input type="checkbox"/> Behavioral/Psychiatric Office visit <input checked="" type="checkbox"/> Official Medical Record <input type="checkbox"/> Other _____ | Hospital Records (Only From Non-Banner Hospital) <input checked="" type="checkbox"/> All Pertinent Records (includes those listed below) <input type="checkbox"/> Allergies <input type="checkbox"/> Consultation <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ER Report <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical <input type="checkbox"/> Laboratory <input type="checkbox"/> Medication List <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Problem List <input type="checkbox"/> X-Ray Report <input type="checkbox"/> Other _____ |
| | Other Records: <input type="checkbox"/> Billing Record <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Photos Further explanation of request: _____ | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Delivery of Records: | Paper Requests <input checked="" type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Courier <input type="checkbox"/> Fax Electronic Requests <input type="checkbox"/> E-mail <input type="checkbox"/> CD <input type="checkbox"/> I Do Not want my electronic record Encrypted <input type="checkbox"/> I Do want my electronic record Encrypted | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1" style="margin: auto;"> <tr><td colspan="20" style="text-align: center;">Email Address for record delivery</td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table> <p style="text-align: center;">(Complete ONLY if requesting records via Email) *Unencrypted data sent by email can be intercepted by Unauthorized Parties*</p> | Email Address for record delivery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address for record delivery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|-----------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Purpose: | <input type="checkbox"/> Self <input checked="" type="checkbox"/> Continuing Care <input type="checkbox"/> Other (please specify): _____ |
|-----------------|------------------------------------------------------------------------------------------------------------------------------------------|





AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing: my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Banner will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Banner Health's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that I have a right to receive a copy of this authorization.

This Authorization pertains to the dates specified on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Banner Health, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient _____ **Date** _____

Signature of Legal Representative _____ Date _____

Relationship to Patient: _____

| For Healthcare Use Only | | |
|------------------------------------------------------------------------|-----------------|----------------------|
| Employee printed name who completed/reviewed form with patient: | | |
| Verbal Release or Viewed EMR (document information/person authorized): | | |
| Date Received: | Date Completed: | Processing Initials: |
| POA Verified: | ID/License#: | |
| Comments for CROI: | | |

Records picked up by: _____ Date _____



AUTHORIZATION FOR RELEASE OF MEDICAL AND FINANCIAL INFORMATION
(To be filled out by patient pharmacy advocate)

| | |
|--------------------------------------------------|------------------------|
| Organization Who Is Releasing Information | |
| Facility: BFP - BUMCT | |
| Address: 1501 N Campbell Ave | |
| City, State: Tucson, AZ | Zip Code: 85724 |
| Fax: | Phone: 520-694-6193 |

| | | |
|-----------------------------|---------------------|----------------------|
| Patient Information: | Patient Name: _____ | Date of Birth: _____ |
| | Address: _____ | Phone Number: _____ |
| Dates Requested: | FROM: _____ | TO: _____ |

| | |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Records Authorized for Release | ALL RECORDS PERTAINING TO: DIAGNOSIS, LABORATORY, MEDICATION HISTORY, IMAGING RECORDS/REPORTS, CLINICAL NOTE INFORMATION (INCLUDING HISTORY AND PHYSICAL NOTES) |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|



**AUTHORIZATION FOR RELEASE OF MEDICAL AND FINANCIAL INFORMATION
(To be filled out by patient pharmacy advocate)**

I authorize Banner Health to release medical and financial information about me to a drug manufacturer, charitable organization or other third party for the purpose of applying for financial assistance to help me pay for a medication (or medications) that have been prescribed for me. Banner Health will only release the medical and financial information required for the financial assistance application. Such information may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, as well as information relating to Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing. My signature authorizes release of all such information if it is required for the financial assistance application.

I may refuse to sign this authorization form. I understand that Banner will not condition or deny treatment on my signing this authorization. However, I also understand that if I do not sign this authorization Banner will not be able to apply for financial assistance to help me pay for medications.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Banner Health's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that I have a right to receive a copy of this authorization.

Unless I revoke this authorization earlier, it will expire at the completion of treatment with the medication for which I am seeking financial assistance. I understand that if this information is disclosed to a third party, the information may no longer be protected by state or federal regulations and may be re-disclosed by the person or organization that receives the information.

I also authorize Banner Health to provide my personal and financial information to the drug manufacturer, charitable organization or other third party if it is required for the financial assistance application. Such information may include the following: my name and address, my household income and size, and my financial obligations.

I release Banner Health, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

DO THE REQUESTED RECORDS INCLUDE DRUG/ALCOHOL TREATMENT

RECEIVED: Yes No If yes, I release my drug and alcohol information for the following purpose: To apply for financial assistance from drug manufacturers or charitable foundations to pay for my medication[s].

The information to be released should include my entire record requested except for the following:

Signature of Patient _____ Date _____

Signature of Legal Representative _____ Date _____

Relationship to Patient: _____

Arizona Ryan White and ADAP Application

RWPA/B/ADAP/DENTAL ATTESTATION and RELEASE OF INFORMATION

Please review each statement and sign below:

- I may qualify for Ryan White funded services even if I have other insurance.
- I will report any changes to my household income, my address, and other things that may affect my services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program.
- At least every six months, I will complete the required eligibility process or I may not remain in the program.
- The information provided in this application is accurate and complete to the best of my knowledge. Any unreported items may prevent, delay a decision about my eligibility, or result in loss of eligibility.
- I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Client Rights/Responsibilities, and Client Grievance Policy, as applicable.
- My enrollment may be terminated if I exhibit violent or threatening behavior to any Ryan White/ADAP Program representatives.

I, _____ (Client Name), authorize Care Directions, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Maricopa County Employee Benefits and Health, Ebony House, Maricopa Integrated Health System, Maricopa County Office of Health Education & Promotion, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS, Sun Life, Terros, Ryan White HIV/AIDS Program Grantees and/or Contractors, all Ryan White Part B Grantees and/or Contractors, SAAF/Delta Dental and ADAP to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (RWHAP) Grantee or Contractor operating in the State of Arizona.

The purpose of the disclosure is to permit RWHAP Grantees and/or Contractors to exchange my PHI or other information from my records to Ryan White Contractors and Grantees for the purposes of:

- Continuity of care, treatment, payment, and health care operations, including eligibility, demographic, health insurance premium and copay payment, emergency treatment, and/or payments to Contractors or other statistical reporting information;
- Mandated reporting, including client-level data reporting;
- Disclosures required by law;
- Legal process and proceedings;
- Oversight including quality assurance reviews and audits of Ryan White-funded services provided;
- Disclosure to a Medical Examiner;
- Disclosure of notifiable public health conditions; and
- Inclusion in shared data systems for demographic, eligibility, and other statistical reporting;
- If in the course of providing services to a client, a RWHAP Grantee or Contractor identifies information that could be harmful to the client or the public; the provider may report that information to the appropriate authorities.

If required for the purposes listed above, I authorize the disclosure of the following information until the end of the month, one (1) year from the date of my signature below:

- HIV/AIDS and other communicable disease information, including HIV Counseling and Testing;
- Behavioral, Mental Health or Psychiatric treatment information; and/or
- Substance abuse treatment information.

Unless I revoke this authorization earlier, it will expire at the end of the month, one (1) year from the date of my signature below. I also understand that my revocation will not apply to information that has already been released in response to this release. To revoke this authorization, I must submit a written request to the following agencies:

Central Eligibility Office, Care Directions, 1366 E. Thomas Road, Suite 203, Phoenix, AZ 85014 OR
Arizona Department Health Services, 150 N. 18th Ave. Suite 130, Phoenix, AZ. 85007

By signing this Release of Information, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this Release. I also understand that Ryan White Grantees and Contractors will maintain the confidentiality of my disclosed PHI or other information, and that they will use my PHI or other information only for the purposes listed above.

Printed Name

Signature

Date

Signature of Legal Representative

Relationship to Client