COCHISE COUNTY

ATTORNEY'S OFFICE

BRIAN M. McINTYRE
COCHISE COUNTY ATTORNEY

Release of Information

Client / Defendant Full Name:_____ Date of Birth:_____ Phone Number: _____

Address: _____

To provide information TO/FROM:

Person/Provider: **CCAO/GRACe Program.**

Address: **150 Quality Hill, Bisbee, AZ 85603**

Phone Number: **520-432-8738**

This authorizes:

Person/Provider: **Cochise County Public Defender.**

Address: **4 Ledge Ave. Bisbee, AZ 85603**

Phone Number: **520-432-8440**

General Permissions: ☒Medical ☐ Dental

- ☐ 3 months of the most recent records
- ☐ Lab Dates (from)_____(to)_____
- ☒ Other: Diagnosis /SMI Determination
- ☐ All records (only 2 years, unless other dates are specified)
- ☐ X-rays: Dates (from):_____(to):_____

No more than 50 pages via fax. If more than 50 pages, please mail.

Special Permissions:

Mental/Behavioral Health Services

- ☐ All mental/behavioral health/psychotherapy records
- ☐ Only psychotherapy records
- ☐ I want to review these records before they are released. I understand my review will be supervised in the Health Information Management Department.
- ☐ Do not release this information

Drug/Alcohol/Medication Assisted Therapy

- ☐ Include all Drug/Alcohol/MAT records
- ☐ Include only the specific information:
  - ☐ Clinical Notes and Discharge Summaries (including therapy notes)
  - ☐ Lab & Other Diagnostic Test Results
  - ☐ Assessment/Screening Results
- ☐ Do not release this information

HIV/AIDS Information

- ☐ Include this information in the release
- ☐ Do not release this information

Purpose for need of disclosure:

- ☐ At the request of the individual to transfer care
- ☐ At the request of the individual to coordinate care

I understand that my medical records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, **42 C.F.R. Part 2**, and the **Health Information Portability and Accountability Act (HIPAA)**, **45 C.F.R. Parts 160 and 164**, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations.

I understand that **I have a right to revoke this authorization** at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocations will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: ___/___/___, or if I fail to specify an expiration date, **this authorization will expire in one (1) year.**

I understand that authorizing the disclosure of this health information is voluntary. **I can refuse to sign this authorization.** I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed, as provided in **CFR 164.524.** I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

_____ _____

Signature of Client/Defendant Date

_____ _____

Signature of Witness Relationship to Client/Defendant