ADELANTE HEALTHCARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) BY PHONE OR IN-PERSON

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I give Adelante Healthcare permission to verbally discuss and/or leave messages about my Protected Health Information (PHI) in the manner indicated on this authorization form. I am aware of who may answer the telephone at the numbers I provided. I am comfortable with Adelante Healthcare leaving detailed messages at these telephone numbers and/or on the patient portal. In addition to my medical/dental care information, Adelante Healthcare can disclose/discuss the following super-confidential information (please check all that apply):

☐ Mental Health	☐ Sexually transmitted infections/diseases
☐ Alcohol abuse or test results	☐ Sexual Assault Nurse Examiner Program (SANE) documents
☐ Drug/substance abuse or test results	☐ Developmental disabilities
☐ Psychotherapy records	☐ HIV test results, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related disease

This authorization does not allow Adelante Healthcare to release copies of my PHI to anyone.

In order to obtain a full or partial copy of your medical record you must: 1) Complete a Request for Medical Records Form and provide proof of identification; or 2) Forward a notarized letter requesting your complete or partial medical records; this letter must include your first name, last name, date of birth, social security number (if available), address and phone number where you may be reached; 3) Your power-of-attorney may request complete or partial records with proof of status and proof of identification by either method of request above. Adelante Healthcare reserves the right to charge a per page fee. Records will be released after invoices are paid in full. Processing may take up to 30 days.

The person(s) I authorize to receive my PHI is not required to follow the federal privacy standards. I understand that he or she may share my PHI without my knowledge or authorization. Adelante Healthcare is not responsible for any claims and/or damages arising from discussing my PHI in response to this authorization.

I acknowledge that I am not required to sign this authorization form. Adelante Healthcare may not condition treatment or payment for health care based on whether I sign this form.

This authorization is effective until my legal guardian, my legal representative, my representative, or I cancel it. I have the right to cancel this authorization at any time by sending a written request to the Adelante Health Center where I receive care or to Adelante Healthcare Center Support Office, Attn: Medical Records Department, 3033 N Central Ave Ste 145, Phoenix, Az 85012. Cancellation does not apply to PHI already released in response to this authorization.

If any of the information I listed on this form changes, I will request and complete a new authorization form. I understand that Adelante Healthcare will continue to release information as listed on this authorization form until I complete a new form or cancel this form.

_____	_____
Patient's First Name/Middle Initial/Last Name	Date of Birth

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) BY PHONE OR IN-PERSON

I give Adelante Healthcare permission to leave messages and communicate verbally on the telephone or face-to-face detailed protected health information (PHI) known about me now and in the future. Adelante Healthcare may leave general telephone appointment reminders and messages requesting that I call back even if I do not sign this form.

☐ Yes

☐ No

PHI that may be discussed and/or messages left include:

- *Appointment reminders (provider name and department)*
- *Test and procedure results*
- *Billing or payment information*
- *Referral Information*
- *Other health information*

(If "Yes", complete this form. If "No", do not answer the following questions)

Home Number:	☐ Yes	☐ No
Cell Phone Number:	☐ Yes	☐ No
Work Phone Number:	☐ Yes	☐ No

Adelante is authorized to discuss my care with:

Name	Relationship	Gender
Name	Relationship	Gender
Name	Relationship	Gender
Name	Relationship	Gender

I understand what information about me may be communicated with my contacts. This accurately reflects my wishes. I authorize Adelante Healthcare to use the information I have provided on both pages of this form.

Patient or Legal Guardian Signature _____ Date _____

Adelante Witness (only required if patient or guardian unable to sign) _____ Date _____