CODAC
HEALTH • RECOVERY • WELLNESS

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Please send all Medical Records requests to:

Email: MedRecords@codac.org **Phone:** (520) 327-4505 **Fax:** (520) 202-1703

Records requests specific to **CODAC at 380 (MAT Services 24/7)** **Phone:** (520) 202-1786 **Fax:** (520) 792-4977
Records requests specific to **SACASA Program** **Phone:** (520) 327-1171 **Fax:** (520) 327-2992

NAME: _____ **DOB:** _____ **SSN (OPTIONAL):** _____

I hereby authorize CODAC Health, Recovery & Wellness, Inc. or its agents to both receive or disclose the specified protected health information to the following person(s)/organization by either written or verbal means:

NAME: _____ **PHONE:** _____ **FAX:** _____

ADDRESS/CITY/STATE/ZIP: _____

PURPOSE OF DISCLOSURE: _____

INFORMATION TO BE RELEASED (Select option for "ALL" or select the specific protected health information to be released:

☐ ***ALL contents of my medical record, including information related to HIV, AIDS, other communicable diseases AND Substance Use**

MEDICAL	CLINICAL	OTHER Specific Content
☐ Diagnosis	☐ Assessments	☐ Discharge Summary
☐ Laboratory and Diagnostic Records	☐ Monthly Summaries	☐ Emergency Contact
☐ Medications	☐ Psychotherapy/Counseling Notes	☐ Verbal Consult - Reciprocal
☐ Psychiatric Evaluations	☐ Social History	
☐ PCP Documents	☐ Service Plan	*☐ Substance Use Information
☐ Women's Health Documents	☐ Updates on my status or condition	*☐ HIV/AIDS/Other Communicable Diseases

☐ Other: _____

* I understand that federal and state confidentiality laws protect any information regarding substance use and/or communicable disease. I further understand that the recipient of any such information is prohibited from re-disclosure of that information without my express written consent unless otherwise permitted to do so by law.

This authorization will expire one year from the day of signing. I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. My signature below confirms I have read the above and authorize the disclosure of the stated protected health information stated.

MEMBER/GUARDIAN SIGNATURE: _____ **DATE:** _____

PRINT GUARDIAN NAME & RELATION: _____

STAFF SIGNATURE (Witness): _____ **DATE:** _____

REVOCATION: I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

REVOCATION DATE (TODAY): _____

MEMBER/GUARDIAN SIGNATURE: _____ **DATE:** _____

PRINT GUARDIAN NAME & RELATION: _____

WITNESS SIGNATURE: _____ **DATE:** _____

Notice that CODAC will not condition treatment, payment, or health care operations on whether the member signs the authorization and Potential for the PHI/EPH disclosed to be subject to re-disclosure by the recipient and no longer protected. This information comes from confidential records and further disclosure without the express written consent of the protected person is not permitted by law. Disclosure of substance abuse records are with client's consent per (42CFR Part 2). Disclosure of communicable disease related information, pursuant to this release cannot be redisclosed without specific written authorization. (A.R.S. 36-664.H)

* BLANK CONSENT FORMS SIGNED BY CLIENT DO NOT MEET COMPLIANCE STANDARDS*