

East Valley Diabetes & Endocrinology
4100 S Lindsay Road, Suite 130, Gilbert, AZ 85297

AUTHORIZATION FOR DISCLOSURE OF PHI TO A FAMILY MEMBER OR OTHER DESIGNATED PERSON
45 CFR § 164.508 | A.R.S. §§ 12-2291–12-2295. Written authorization is required before PHI may be disclosed to anyone other than the patient or health care decision maker.

1. Patient Information

Patient Name: DOB: MRN:

2. Person(s) Authorized to Receive Information

I authorize East Valley Diabetes & Endocrinology to disclose my PHI to:

Table with 3 columns: Name, Relationship to Patient, Phone Number. Contains 4 empty rows for authorized persons.

3. Information to Be Disclosed

Entire record Diagnosis/treatment Labs/results Medications Billing/insurance Scheduling Phone discussion w/ staff
Other:
Substance use disorder (42 CFR Part 2), behavioral/mental health, and HIV/AIDS information require separate initials: Minors: Arizona law lets minors independently consent to certain care (behavioral health, reproductive health, substance abuse); a parent's signature alone may not authorize release of those records.

4. Purpose and Expiration

Keep family/caregiver informed Care coordination Billing/insurance Other:
Expires 1 year from signature Specific date: Specific event:

5. Revocation and Redisclosure

I may revoke this authorization at any time in writing to East Valley Diabetes & Endocrinology, except to the extent already relied upon. Signing is voluntary and not a condition of treatment, payment, or benefits. Once disclosed, this information may no longer be protected by HIPAA and may be redisclosed by the recipient unless otherwise prohibited by law.

6. Signature

Patient Signature: Date:
If signed by a health care decision maker (A.R.S. § 12-2291) — parent of a minor, guardian, or health care POA agent — complete below:
Representative Name: Relationship/Authority:
Representative Signature: Date: