Gilbert Center
For Family Medicine

652 E. Warner Rd, Suite 107 Gilbert, AZ 85296
Phone: *480-539-8680* **Fax:** *480-539-1763*
WWW.GILBERTCENTER.NET

Patient Name: _____ Date of Birth: _____

RELEASE OF INFORMATION AND AUTHORIZATION

Purpose of Disclosure: ☐ Authorized contact for my care ☐ Other: _____

At the patients request, as indicated above, I authorize the staff of Gilbert Center for Family Medicine to release Protected Health Information (PHI) to the individuals listed below. PHI includes but is not limited to treatment records, medications/prescriptions, and test results. This authorization will be valid for one year from the signature dated below.

Authorized Person	Relationship to Patient	Contact Number

Sensitive Record Categories:

The following record types are protected by Arizona and federal law and require your separate, affirmative consent before they may be released. Please initial each category you wish to include. Categories left blank will be excluded from this release.

Initials	Record Category	Legal Authority
	HIV test results and related information	*A.R.S. § 36-664*
	Mental health and behavioral health treatment records	*A.R.S. § 36-509*
	Alcohol and substance use disorder treatment records	*42 CFR Part 2*

Right to Revoke: *You may revoke this authorization in writing at any time by contacting GCFM's Privacy Officer at 652 E. Warner Rd, Suite 107, Gilbert, AZ 85296. Revocation does not affect disclosures already made in reliance on this authorization.*

Treatment Not Conditioned on Signing: *Your treatment, payment, enrollment, or eligibility for benefits at GCFM is not conditioned on signing this authorization. (45 CFR §164.508)*

Re-disclosure Notice: *Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA or Arizona law.*

I hereby acknowledge that I may review Gilbert Center for Family Medicine's Privacy Practice Notice by visiting www.gilbertcenter.net. A signed copy of this authorization will be provided to you at the time of signing.

CONCENT TO LEAVE VOICEMAIL

GCFM may leave general appointment and administrative messages by default. If you choose to authorize it, GCFM staff may also leave detailed medical information on your voicemail when calls are unanswered, including treatment recommendations, medications/prescriptions, and test results. HIV results and confidential alcohol, drug abuse, and mental health details require separate affirmative consent and will only be disclosed by voicemail if specifically authorized below.

☐ ***I AUTHORIZE detailed voicemail as described above.***

☐ ***I ALSO AUTHORIZE*** *HIV results, behavioral health, and substance use details by voicemail. (A.R.S. § 36-509 / 42 CFR Part 2)*

☐ ***I DECLINE*** *— Leave general/administrative messages only. (Default if unsigned)*

HEALTH INFORMATION EXCHANGE

By signing below, you consent to Gilbert Center for Family Medicine's participation in the Health Current (HC) Health Information Exchange, which allows your health information — including mental health details — to be securely shared with other participating providers for treatment, payment, care coordination, and healthcare operations. **HIV test results and substance use disorder records subject to 42 CFR Part 2 are excluded from Health Current sharing unless separately authorized.** If you wish to opt out, please notify a staff member; processing may take up to 30 business days.

☐ **I DECLINE** the HIE Agreement and would like to fill out the Opt-Out Form

_____ _____ _____

Patient Signature Date of Birth Date

_____ _____

Legal Representative Signature Relationship to Patient/ Representative's Authority (e.g. Power of Attorney)