Authorization for Disclosure of Protected Health Information (PHI)

1. I authorize: *Matrix Medical Network* to release protected health information (PHI) from the records of:

Please print first and last name

Member's Name*: _____

(MM/DD/YYYY) Please include area code

Date of Birth*: _____ Phone Number: _____

Health Plan: _____ Member ID: _____

(MM/DD/YYYY)

Date of Service Requested*: _____

2. Health information to be disclosed* (check all applicable items to be released):

☐ Comprehensive Health Assessment (CHA) ☐ Personalized Health Summary (PHS) ☐ Addendum
☐ Lab Results ☐ Other: _____

3. My health information will be disclosed to: (Please select one choice only)

☐ Member (Self)
☐ Legal Representative
☐ Physician or Specialist

Please print first and last name

_____

Please print mailing address Please include apt, unit or lot number

Please mail my records to*: _____

City: _____ St: _____ Zip Code: _____

4. I understand the PHI in my health record may include information I provided to my health provider during the visit which may contain sensitive health information, behavioral or mental health services, and/or laboratory test results.

5. I understand I have the right to revoke this authorization at any time by sending written revocation to Matrix Medical Network to the address provided below. I understand the revocation will not apply to information that has been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months from the date of signature (#8).

6. I understand that by signing this authorization form I authorize Matrix to release additional records upon request.

7. I understand that authorizing the disclosure of my PHI is voluntary. I can refuse to sign this authorization. My refusal will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. **However, information will not be released to the above-indicated recipient (#3) without my signature and date (#8) or my legal representative's signature and date (#8).**

Signature of Member or Legal Representative* Date*

8. _____ _____

If signed by Legal Representative, relationship to member*: ☐ Health Care Power of Attorney ☐ Legal Guardian ☐ Executor of Estate

9. **Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.**

10. For questions about the disclosure of your protected health information (PHI), please contact our compliance hotline at **1-800-863-6599.**

11. If you have any questions on how to fill out this form, please call **1-877-561-5750.**

Please **mail this entire form** to the following address:
Business Services – Member Requests
Matrix Medical Network
9201 E. Mountain View Road, Suite 220
Scottsdale, AZ 85258

If you would like to fax your request, please use our **Secure Fax Line** at:
1-877-561-7492 Toll Free
480-323-2570 Local (Arizona)