Application for Holy Orders
Form 4 – HIPAA
HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHOLOGICAL/PSYCHIATRIC RECORDS

Patient Name:_____ Health Record Number_____

Date of Birth: _____ SSN_____

I authorize the use or disclosure of the above named individual's protected health information as described below:

1. The following named individual or organization is authorized to make the disclosure:

   _____

2. The type and amount of information to be used or disclosed is as follows:
X The complete report of my medical records.
X The complete report of my psychological examination.
X The complete report of my psychological evaluation.

3. This information may be disclosed to and used by The Episcopal Diocese of Arizona at 114 West Roosevelt Street in Phoenix Arizona 85003-1406, for the purpose of processing the patient's application for Holy Orders and retained in the permanent file of the Diocese.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
   Unless otherwise revoked, this authorization will expire three years from the date below.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. The physician-patient or other privilege is not waived. You are specifically requested and instructed not to disclose any information, opinions, records or x-rays to any other attorney, physician, insurance company or person without specific additional written authorization from me to do so, unless said disclosure is necessary for health care or health insurance purpose. ARS § 12-2235. All other authorizations are hereby revoked and canceled.

8. Photocopies of this authorization will be considered as valid as the original.

_____ DATED this _____ day of _____, 20__.
Signature of Patient or Legal Representative

_____
Signed by Legal Representative, Relationship to Patient Signature of Witness