Maricopa Integrated Health Systems
Attn: Medical Records
2601 E. Roosevelt
Phoenix, AZ 85008
602-344-5221

10/23/2007

RE: FLORES, FRANCISCO
MRN: 32873697

We are unable to process your request for medical records at this time. The patient authorization for release of information form is incomplete or not HIPAA compliant. Please resubmit your request with the following:

____ A statement of prohibition of re-disclosure is needed.

____ The right to revoke this authorization is not stated.

____ Authorization must specify Maricopa Integrated Health System is to release information.

____ The purpose for request is not stated.

____ Authorization must be signed by the patient.

____ Please provide us with an updated authorization form (signed and dated after the dates of treatment).

____ Authorization is over six months old. Please submit a current, updated patient authorization form.

____ Please submit an authorization form signed by the patient authorizing release of patient information to your facility.

____ Authorization form must contain a complete name and address as to where the patient's information is to be sent.

✓ Please have the patient complete the attached authorization form and return to us.

Sincerely, Need HIPPA Auth, Letter of Rep.

MARICOPA INTEGRATED HEALTH SYSTEM

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Maricopa Integrated Health System to disclose protected health information ("PHI") from the health records of:

Patient Name:_____
Address:_____
Phone Number:_____
Date of Birth:_____SS#:_____
I authorize PHI from _____[date] to_____[date] to be disclosed to
_____at
_____[address];
_____[phone number if known];_____[fax number if known].

Specific description of the information to be disclosed:

_____ Discharge Summary
_____ History and Physical Exam
_____ Operative Reports
_____ X-ray Reports
_____ EKG's
_____ Lab Tests

Specific description of the purposes of the disclosure:

_____ Continued Patient Care
_____ Workers' Compensation
_____ Insurance Coverage or Payment for Care
_____ Other (specify)_____

-OR-

_____ The disclosure is at my (the patient's) request

I authorize the provider to use or disclose information related to (check all that apply):

_____ AIDS/HIV and other Communicable Diseases
_____ Behavioral Health Care/Psychiatric Care/Mental Health Information
_____ Alcohol and/or Drug Abuse Treatment
_____ Genetic Testing Information

The provider will not deny me treatment if I do not wish to sign this form. I understand that I may refuse to sign this authorization form

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the provider's Notice of Privacy Practices.

Unless I revoke this authorization earlier, it will expire 90 days from the date signed. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person/organization that receives the information

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description of Authority to Act for Patient