

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ ("Facility") to disclose protected health information ("PHI") for the health records of:

Patient name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Area Code: _____ Number: _____

To the following person or entity:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone (If known): Area Code: _____ Number: _____ Fax: _____

Specific description of the information to be disclosed: Date of Service: _____

- | | |
|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other: _____ |

Specific description of the purposes of the disclosure:

- | | |
|---|---|
| <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Insurance Coverage or Payment for Care |
| <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> Other: _____ |

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

- AIDS/HIV and other communicable disease
- Behavioral Healthcare/Psychiatric Care/Mental Health Information
- Alcohol and/or Drug Abuse Treatment
- Genetic Testing Information

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

I also understand that I may revoke this authorization at any time, unless the Facility has relied on this authorization and already released the information. Unless I revoke this authorization earlier, it will expire in one year. To revoke my authorization, I must submit a written request to the Medical Records Custodian at the applicable facility: Flagstaff Medical Center, 1200 N. Beaver Street, Flagstaff, AZ 86001; Verde Valley Medical Center, 269 S. Candy Lane, Cottonwood, AZ 86326; or Northern Arizona Homecare, 107 E. Oak Avenue, Flagstaff, AZ 86001.

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 a third party.

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.

Signature of Patient/Patient's Legal Representative

Date