Northern Arizona Healthcare

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE FAX STAT TO _____

I authorize _____ **to disclose the following information from the health record of:**

(Enter Hospital name or Clinic name)

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ MRN # (for internal use only) _____

Address _____ Area Code and Phone Number _____

City _____ State _____ Zip Code _____

INFORMATION REQUESTED (Most Recent)

Service Dates From: _____ **To:** _____

- ☐ All Pertinent Records
- ☐ Allergies
- ☐ Consultation
- ☐ Discharge Summary
- ☐ ER Report
- ☐ Most recent EKG Rpt
- ☐ History & Physical
- ☐ Labs (last 3 months)
- ☐ Medication List
- ☐ Echocardiogram
- ☐ Other _____
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Radiology Reports
- ☐ Discharge Instructions
- ☐ X-ray Images/Report
- ☐ Billing Record
- ☐ Entire Medical Record
- ☐ MRSA Swab/Result
- ☐ Most recent Pre-op Eval
- ☐ Stress Test w/nuc imaging

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

- ☐ Behavioral Health/Psychiatric/Mental Health Information
- ☐ AIDS/HIV and Other Communicable Disease
- ☐ Alcohol and/or Substance Abuse Screening and/or Treatment
- ☐ Genetic Testing

Method of Delivery _____

☐ Call When Ready ☐ Paper Request ☐ CD

PRE-OP CLEARANCE

- ☐ Echo/Pacemaker Interrogation/Cath Report
- ☐ Cardiac Note/Clearance
- ☐ Anesthesia Risk Assessment
- ☐ Written Aspirin/Plavix/Anticoagulation Instruction

CLINIC / OFFICE RECORDS

- ☐ Clinic / Office Notes
- ☐ Discharge Summary
- ☐ H & P
- ☐ OP Report
- ☐ Lab Tests
- ☐ Progress Notes
- ☐ X-Ray Reports
- ☐ Others

PURPOSE

- ☐ Self
- ☐ Continuing Medical Care / Surgery
- ☐ Workmen's Compensation
- ☐ Insurance Coverage
- ☐ Other: _____

INFORMATION to be VIEWED BY OR GIVEN TO

Company, Person, Facility _____ Area Code and Phone Number _____

Street Address _____ Area Code and Fax Number _____

City _____ State _____ Zip Code _____

I may refuse to sign this authorization form. I understand that the Facility will not condition or deny treatment on my signing this authorization.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Healthcare/Psychiatric Care, Treatment of Alcohol and/or Drug Abuse, and Genetic Testing; My signature authorizes release of any such information.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. 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 St., Flagstaff, AZ 86001; Verde Valley Medical Center, 269 S. Candy Lane, Cottonwood, AZ 86326 or Northern Arizona Home care, 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 state, federal regulations and may be re-disclosed by the person or organization that receives the information.

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.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature _____ Date Time

Printed Name _____

Patient Authorized Representative Signature _____ Date Time

Printed Name _____

☐ Legal Guardian ☐ Power of Attorney ☐ Surrogate Decision Maker ☐ Patient Representative ☐ Minor ☐ Patient Deceased ☐ Other _____

For Healthcare Use Only

Employee completed/reviewed form with patient: _____ **ID verified** _____

Date Received: _____ **Date Sent:** _____ **Date Faxed** _____ **# of pages** _____

Copy Service: _____ **Date Copied:** _____ **Completed By:** _____ **Emailed to Copy Service on:** _____

ROI