Patient Name (print) _____ Date of Birth___/___/_____ Phone number_____

Address: _____ City_____ State_____ Zip_____

I, the undersigned, authorize the disclosure (release) of, or request access to, the **Protected Health Information (PHI)** from the health records of the above named patient to the individual or organization as follows:

From: (the entity to disclose the records)

Name_____

Address_____

City_____ State _____ Zip_____

Phone_____ Fax_____

To: (the entity to receive or have access to the records)

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

Dates of Service: I authorized this disclosure as follows: **Begin** (date)_____ **End** (date)_____

COMPLETE ALL 3 BOXES — **CHECK ALL THAT APPLY**

Specific patient information to be disclosed or accessed:

- ☐ The entire legal medical record
- ☐ Discharge / Death Summary
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ Radiology Reports ☐ Images / CD
- ☐ Lab / Pathology Reports
- ☐ Progress Notes
- ☐ Consultations
- ☐ Emergency Room Record
- ☐ Demographics / Face Sheet
- ☐ Other_____

Disclosure of Protected Information: Only Summit generated records will be released. Do you want the following information to be disclosed or accessed?

YES	NO	
☐	☐	AIDS/HIV and other Communicable Disease
☐	☐	Behavioral/Mental Health
☐	☐	Substance Use / Treatment
☐	☐	Genetic Testing
☐	☐	Psychiatric Care (IP) +
☐	☐	Psychotherapy Notes (OP) +

(+ if present, release requires provider approval)

Specific purpose for the patient information to be disclosed or accessed:

- ☐ Continuity of Medical Care
- ☐ Insurance Coverage or Payment
- ☐ Worker's Compensation
- ☐ Military
- ☐ School
- ☐ Social Security / Disability
- ☐ Legal
- ☐ Personal Use
- ☐ Other_____

I understand Summit Healthcare Association (Summit) will not condition treatment on my signing this authorization. Summit 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 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 Summit Healthcare's Notice of Privacy Practices. To revoke my authorization, I must submit a written request to the Medical Records Department. This authorization will expire in one year, or earlier on the following date:_____. If date is left blank, it is understood the expiration date will be one year from patient signature date.

I understand, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and **may be redisclosed** by the person or organization that receives the information. **Exception: ***Protected Information listed above may NOT be redisclosed.**

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.

_____ ___/___/_____

Patient Signature *(provide photocopy of picture I.D.)* Date Time

_____ _____

Signature of Legal Representative *(provide photocopy of legal document and photo ID)* Relationship to Patient (or) Description of Authority

NOTE: Federal law/42 CFR Part 2 prohibits unauthorized disclosure of these records

Records released by (print name)

_____ Dept_____

Medical Record # _____

☐ (+) Provider _____ contacted regarding request:

- ☐ approved release
- ☐ did not approve release

Contact # _____

- ☐ Translation _____
- ☐ Faxed to the requestor
- ☐ Mailed to the requestor
- ☐ Given to the requestor
- ☐ See attachment

_____

Staff Signature Date/Time

Pt Name:

Acct# MR#

Adm: DOB:

Summit Healthcare Regional Medical Center

Summit Healthcare

2200 E Show Low Lake Rd • Show Low, AZ 85901

227 (10/19)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

ROI