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 person(s) or organization(s) 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 ☐ Lab / Pathology Reports ☐ Progress Notes ☐ Consultations ☐ Emergency Room Record ☐ Demographics / Face Sheet ☐ Other_____	**Disclosure of specific *Protected Health Information (PHI):** Do you want the following information to be disclosed or accessed? YES NO ☐ ☐ AIDS/HIV and other Communicable Disease ☐ ☐ Genetic Testing ***Exception: PHI listed above may NOT be re-disclosed.** **If requesting psychotherapy notes, please complete separate release form.	**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 ☐ At the request of the individual ☐ Other_____

I understand that 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 authorization form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, except if and to the extent that Summit has already taken action in reliance on this authorization. To revoke my authorization, I can send a written request to Summit Health Information Management at 2200 E. Show Low Lake Rd., Show Low, Arizona 85901.

This authorization will expire on the following date: _____ ,
or if left blank, the expiration date will be one year from date of signature below.

I understand that my health information may be subject to re-disclosure by the recipient. If this information is re-disclosed by the recipient to a third party, the information may no longer be protected under federal privacy regulations.

I understand the matters discussed on this form. I release Summit, including its providers, 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

_____ _____

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

Format requested and provided:

☐ Translation _____
☐ Faxed to the requestor
☐ Mailed to the requestor
☐ Hand delivered to the requestor
☐ Encrypted Email to the requestor
☐ Email *(I have informed the patient that unencrypted email is not secure).*
☐ Released to Patient Portal
☐ Other format: _____

Records released by:

_____ _____

Name Printed Department

Medical Record #_____

_____

Staff Signature Date/Time