

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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

PATIENT INFORMATION				
Name:		Date of Birth:		
INFORMATION REQUESTED				
<input type="checkbox"/> All Pertinent Records (includes all listed) <input type="checkbox"/> Allergies <input type="checkbox"/> Consultation	<input type="checkbox"/> History & Physical <input type="checkbox"/> Laboratory <input type="checkbox"/> Medication List <input type="checkbox"/> Pathology Report	<input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Assessments <input type="checkbox"/> x-ray images <input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Billing Record <input type="checkbox"/> Photo <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Problem List	<input type="checkbox"/> ER Report <input type="checkbox"/> Operative Report <input type="checkbox"/> EKG Report
PURPOSE				
<input type="checkbox"/> Self <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Other(specify reason)				
INFORMATION TO VIEWED or GIVEN TO				
Company, Person, Facility:		Phone:	Fax:	
DESERT SENITA COMMUNITY HEALTH CENTER 410 N MALACATE ST AJO, AZ 85321		(520) 387-5651	(520) 387-6036	
ACKNOWLEDGEMENT				
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 Health Care/ Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes release of any such information. I may refuse to sign this authorization form. I understand that Desert Senita will not condition or deny treatment on my signing this authorization. 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. Desert Senita's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, it will expire 12 months from the date signed or as specified: __/__/__ 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 release Desert Senita, its employees and agents, 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		Date:		
In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.				
* Signature of Legal Representative Relationship to Patient or Description of Authority to Act for Patient		Date:		

For Healthcare Use Only:
Employee completed/reviewed form with patient:
Date Received:
Date Sent:
ID Verified:

