NAME ______________________ DOB ____________ ACCT ____________

AUTHORIZATION TO USE, DISCLOSE, or RELEASE PROTECTED HEALTH INFORMATION

I ______________________ authorize **Mt. Graham Regional Medical Center** to disclose Protected Health
(Print Name)

Information (PHI) from the health records of: ______________________ DOB: ____________
(Name of Patient)

Address: ______________________ Phone Number: ____________ Email: ____________
(Sent by encryption)

I authorize PHI from ______________________ to be disclosed to myself or:

____
(Name and Address of facility and/or physician receiving information)

Phone: ______________________ Fax: ______________________

Information to be released:

☐ Emergency Room Visit ☐ Inpatient Visit ☐ Operative Reports
☐ Radiology Reports ☐ Lab Results ☐ EKG tracing/report
☐ Other: ______________________

Purpose of information needed:

☐ Personal ☐ Medical ☐ Legal ☐ Insurance ☐ Worker's Compensation ☐ School Requirement
☐ Other: ______________________

I authorize the provider to use or disclose information related to:

☐ AIDS/HIV and other Communicable Disease ☐ Alcohol and/or Drug Abuse Treatment
☐ Genetic Testing Information

I hereby authorize Mt. Graham Regional Medical Center to provide the above named facility or person with a copy of any and all records, documents, reports, including HIV information, clinical abstracts, histories and charts of every kind and description, as indicated above, relating to my treatment and care during above described treatment date(s).

EXPIRATION: This authorization will automatically expire one (1) year from the of execution unless a different event or end date is specified: ______________________

☐ Walk-in ☐ Fax Request ☐ Mail Request ☐ Phone Request Date Completed: ____________

X ______________________
Patient Signature/Legally Authorized Representative

If patient is unable to consent by reason of age or some other factor(s), state reason and relationship: ______________________

____

____

____
Health Information Representative or Witness Signature Date

Phone: 928-348-3813 Fax: 844-660-4726

Information is from confidential records, which are protected by State Law that prohibits further disclosure of the information without specific written consent.

AUTH TO RELEASE PHI