Wickenburg Community Hospital
520 Rose Lane, Wickenburg, AZ 85390
HIM Phone: 928-684-4364 HIM Fax: 928-684-9406

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

I Hereby Authorize:

_____
(Name of person or facility)

_____
(Address)

_____
(Phone) (Fax)

To Release To:

_____
(Name of person or facility)

_____
(Address)

_____
(Phone) (Fax)

Date(s) of Service: _____

Type of Release:

☐Hard Copies (paper) ☐Verbal Exchange (no copies) ☐Review of Record (no copies)

☐Okay to Leave Message at #_____ ☐Other Please Specify: _____

Health Information to be Released:

☐ALL Medical Records ☐Laboratory Reports ☐Radiology Reports ☐Radiology Images

☐Cardiac/EKG Reports ☐Surgery Reports ☐Immunizations ☐Medications

☐Other: _____

Authorization to Release Protected Information: **Required – Complete the check boxes below indicating how protected information should be handled even if the categories do not apply to requested medical records.*

Check one: ***Initial each line:***

____DO/ ___ DO NOT Release **Alcohol and/or Substance Abuse Records** _____

____DO/ ___ DO NOT Release **Genetic Testing Records** _____

____DO/ ___ DO NOT Release **HIV/AIDS & Other Communicable Disease Test Results Records** _____

____DO/ ___ DO NOT Release **Behavioral Health/Mental Health/Psychiatric Treatment Records** _____

Authorization/Revocation:

This authorization will terminate in one year. I understand that I may stop this release at any time by writing to the WCH HIM department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that WCH will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my heal information.

X_____ X_____

Signature **Date**

_____

Relationship to patient (if not patient)