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

Authorization to Disclose Health Information

Patient Name: _____ **Date of Birth:** _____

1 **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email address:** _____

I Hereby Authorize:

_____
(Name of person or facility to give information)

2 _____
(Address of facility)

_____
(Phone) (Fax)

To Release To:

_____
(Name of person or facility to get information)

3 _____
(Address of facility or person)

_____
(Phone) (Fax)

4 **Date(s) of Service:** _____ 5 **Purpose:** _____

6 **Type of Release:**

☐ Hard Copies (Paper) ☐ Verbal Exchange (no copies) ☐ Review of Records (no copies)

7 **Health Information to be Released:**

☐ ALL Medical Records ☐ Laboratory Reports ☐ Radiology Reports ☐ Radiology Image Disk

☐ 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 this request for medical records.*

Check One: **Initial each line:**

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

8 ☐ **DO/** ☐ **DO NOT Release Genetic Testing Records** _____ 9

☐ **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 health information. (**Expires one year from date below**)

10 **X** _____ **X** _____
Signature **Date**

_____
Relationship to patient (if not patient)

Wickenburg Community Hospital

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Wickenburg, AZ 85390
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Authorization to Disclose Health Information Instructions

1. **Please fill out completely your name, date of birth, full address, phone and email**

2. **This is the facility that has your medical records, and you want them to release them.**

3. **This is the facility that you want your medical records to go to. Please make sure you have at minimum phone and fax number.**

4. **Please specific date(s) of service needed or write "Any" then we can then reuse this authorization up to a year from the date it is signed.**

5. **Please write the purpose of this request. (Example: Continuation of Care, Insurance, etc.)**

6. **Please mark one or all on how you would like records released. Hard copies include faxed or emailed as needed.**

7. **Please mark specific records you want released. If you mark "all records" this will capture anything a clinic or you may need in the future.**

8. **Please mark "DO" or "DO NOT" for these specialized records.**

9. **Please initial each line related to Step 8.**

10. **Please have patient sign and date with today's date.**

We are required to have all of this completed for HIPAA regulations. Note this authorization is good for one year from the date it is signed.