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:** _____

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

Phone: _____ **Email address:** _____

I Hereby Authorize:	**To Release To:**
_____	_____
(Name of person or facility to give information)	(Name of person or facility to get information)
_____	_____
(Address of facility)	(Address of facility or person)
_____	_____
(Phone) (Fax)	(Phone) (Fax)

Date(s) of Service: _____

Purpose: ☐ Personal ☐ Continuing Care ☐ Other_____

Delivery of Information:

Paper Request: ☐ Mail ☐ Pick Up Electronic Request: ☐ E-mail ☐ CD ☐ Fax

☐ I ***Do Not*** want my electronic record encrypted ☐ I ***Do*** want my electronic record encrypted

NOTE: There is a level of risk that a third party could access your Protected Health Information (PHI) without your consent when faxed or when electronic media or email is unencrypted. We are not responsible for unauthorized access to faxes, unencrypted media or email or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in any electronic format or email.

Please *EXCLUDE* the following information from being released as part of the release of information request:

- ☐ **Sexually Transmitted Diseases**
- ☐ **Other Sexual Communicable Diseases**
- ☐ **Genetic Testing**
- ☐ **Treatment of Substance Abuse**
- ☐ **Behavioral Health/Psychiatric Care**
- ☐ **HIV/AIDS**

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**)

By accepting the custody of the digital disk/film copies, the patient or designated recipient accepts the risk associated with its loss or theft, in recognition that the data is readable via standard computer programs and as a result, patient privacy is not guaranteed.

X _____ **X** _____

Signature **Date**

_____

Relationship to patient (if not patient)

If patient is unable to consent by reason of age or some other factor, state reasons: _____

_____

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Authorization to Disclose Health Information Instructions

1. **Name, DOB, Address, Phone, and Email:** Please fill out this information completely.

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

3. **To Release To:** 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. **Date(s) of Service:** Please be specific with date or write "Any" then we can then reuse this authorization up to a year from the date it is signed.

5. **Purpose:** Please check or fill in what the reason is for these records.

6. **Delivery Method:** Please check how you want to get your records. (*If you choose to have it emailed you will need to check "Do" or "Do Not" want record encrypted.*)

7. **Excluded Records:** Please check if you want any of these records from the list "Excluded" from this release.

8. **Signature:** Please have patient or patient's representative sign. (If not patient, need to fill in relationship to patient and reason patient is unable to sign.)

9. **Date:** Please 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.